Disability/FMLA Form Request

Coastal Cardiology

DataFile Technologies

Scanned/Faxed by:_____ **Today's Date** _____

4100 N Mulberry Dr. Suite 300
Kansas City, MO 64116
816-437-9134

We are pleased to assist you in completing your Disability and FMLA forms. Be advised there will be a 10 business day processing time frame, as well as a processing fee based on the type of form.

We understand you may have an urgent deadline for your paperwork and will do our best to accommodate; however all paperwork will be processed in the order that we receive it without exception. If you would like a copy of the form for yourself, please contact **Coastal Cardiology** directly.

By law, we are required to have you provide us with a signed authorization giving your permission to disclose your information. By completing the form below, you are authorizing disclosure of your private health information.

***Indicates Required Field**

***Patient's Name** *(First, Middle Initial, Last)*_____

***Date of Birth** _____ ***Preferred Daytime Phone Number** _____

OK to Leave a Detailed Phone Message? □ **Yes** □ **No** **E-Mail Address** _____

□ **Disability forms** ($25) □ **FMLA Forms** ($25)

Date of Symptoms Onset: _____ **First Day Unable To Work**:_____
Length of expected leave:_____

***Name of company or employer to receive form:**

Complete additional copy of this form for each form requested.

Name:_____
Address:_____
_____
Fax:_____

*****Attach this form to the document to be completed for disability determination**

I authorize **Coastal Cardiology** to provide charts, notes, x-rays, operative reports, lab and medication records and all other medical information about me, including medical history, diagnosis, testing, test results, prognosis and treatment of any physical or mental condition, including: any disorder of the immune system, including HIV, AIDS or other related syndromes or complexes; any communicable disease or disorder; any psychiatric or psychological condition, including test results; any condition, treatment, or therapy related to substance abuse, including alcohol and drugs; and any non-medical information requested about me, including things such as education, employment history, earnings or finances, return to work accommodation discussions or evaluations and eligibility for other benefits or leave periods including but not limited to claims status, benefit amount, payments, settlement terms, effective and termination dates, plan or program contributions.

I also acknowledge I am responsible to pay the form completion fee prior to form completion.

Signature: _____ Last 4 digits of your SS# _____
Patient or Authorized Representative's Signature

□ I agree to the terms and conditions and that the information is accurate and verify my identity through this signature.

□ **Signed Release on File**

□ **I approve this form completion.** _____
Provider/Designee Signature

□ **Request denied due to insufficient information.**

□ **Request denied due to scope of patient care. Please contact your primary care provider.**