

Forms & Letters Request



Collected By _____	Today's Date _____	4100 N Mulberry Dr. Suite 300 Kansas City, MO 64116 816-437-9134
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We are pleased to assist you in completing your 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 **Email Address** _____

- Disability Forms (\$25)** **FMLA Forms (\$25)** **Other: DMV, FAA, etc. (\$25)**

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

Brief Description of what you are requesting and why it is needed (please continue on the back, if needed) _____

Complete an additional copy of this page for each request.

***Who needs this form?** _____

Address _____

Fax _____

***Attach this form to the document to be completed.**

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: _____
Patient or Authorized Representative's Signature

Last 4 digits of the patient's SS# _____

- 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.