DESERT WEST
OBSTETRICS & GYNECOLOGY, LTD.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
DISABILITY/FMLA FORMS

Records coming from: Desert West OB/GYN 5601 W Eugie Ave #100 Glendale, AZ 85304
Phone: 602-978-1500 Fax 602-978-1575

Records going to: Name: _____
(Disability) Address: _____
☐ Mail City: _____State: _____ Zip: _____
☐ Fax Phone: _____ Fax: _____

Records going to: Name: _____
(FMLA) Address: _____
☐ Mail City: _____State: _____ Zip: _____
☐ Fax Phone: _____ Fax: _____

Records going to: Name: _____
(Patient) Address: _____
☐ Mail City: _____State: _____ Zip: _____
☐ Fax Phone: _____ Fax: _____
☐ Pick Up

I authorize the release of record(s), including those that may contain confidential HIV/AIDS related information, confidential communicable disease related information and information relating to mental health and alcohol/ drug use. Please release this information to my employer, Disability Company or myself as marked above. This consent shall expire automatically six (6) months from the date on which it was signed.

Print Patient Name _____ **Date of Birth** _____

Signature of Patient/Authorized Person_____

Print Name _____ Date _____

Relationship to Patient _____ **Witness**_____

Please Note: There is a $25 charge per form. This fee is payable prior to completion. Please allow 5-7 business days for completion.

$25 charge for FMLA/Disability form(s). Fee payable prior to completion of form.

Pmt: _____Cash _____CC _____Ck#_____ _____ Emp. Initials

I understand that:

- **FMLA/Disability/Work Accommodation takes 5 – 7 business days to process.**
- **Desert West can only certify 6 - 8 weeks** (time depends on vaginal delivery vs c-section) **of time off for uncomplicated post-partum recovery**. If you would like to use more time, you will need to speak with your pediatrician to certify time for baby bonding.
- You must have been seen within 3 months prior to your paperwork being submitted.
- There is a $25 processing fee for each and every set of paperwork, including renewals for chronic conditions.

- Is there anything else we should know?

_____

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PLEASE NOTE: THIS FORM IS FOR INFORMATION PURPOSES ONLY TO HELP US COMPLETE YOUR FORMS. YOUR MEDICAL RECORD MUST REFLECT ANY AND ALL INFORMATION THAT IS DOCUMENTED ON YOUR FMLA/DISABILITY FORM.

Print name: _____ Date of birth: _____

Signature: _____ Today's date: _____