All About Women's Care

Document Submission Form

There is a $35 charge for completing documents, including disability, FMLA, or any other claim/insurance form. This one-time charge will encompass all paperwork needed for your upcoming delivery, surgery, and recovery.

Please complete the information on your section of the documents before submitting them to the office. Missing portions may delay or lead to rejected paperwork.

Please be advised that if you have any FMLA, disability, return to work, or any biometric screening form that needs to be completed by our office must be submitted **as soon as possible** and no later than ten business days before it is due.

Payment is due upon submission of this form. After payment is received, please allow us up to **TEN BUSINESS DAYS** to have these forms completed for you.

Name:_____DOB:_____

Email: _____

We may need to return your form directly to you. Our office will do so via your best email address.

What date would you like your leave to start?_____

How many weeks will you expect to be out of work? _____

What date do you expect to return to work?_____

Is there any other information you would like to share about your leave or return to work?

_____

Authorization for medical record release:

You may use or disclose the following health care information (check all that apply):

□ All of my health information maintained by All About Women's Care.

□ My health information relating to treatment or condition necessary for documentation.

□ My health information for the date(s): _____

This authorization ends automatically in 180 days.

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study. or
- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. To revoke this authorization, write a letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Signature:_____ Date: _____