EST. 1965
LEE OBSTETRICS & GYNECOLOGY

LEAVE AND FMLA Release of Information

INSTRUCTIONS: Please read this information carefully and fill out all required information before returning this form. Forms to be filled out should be brought into our office or emailed to us at callcenter5@leeobgyn.com. You will need to complete any portion of your employer's required form that pertains to the patient to avoid delays in processing. Please allow up to 10 business days for any form to be completed.

Patient name:_____Date of Birth: _____
Last four of SSN:_____Patient phone number: _____

Optional - if leave paperwork is for caregiver:

Caregiver name:_____Caregiver relationship to patient: _____
Caregiver DOB: _____
Requested method for form to be returned: ☐ **Fax** ☐ **Mail** ☐ **Email to employer** ☐ **Patient Portal** ☐ **Patient pick up**

Expected last date of work:_____Expected return to work date: _____

I authorize Lee Obstetrics and Gynecology to release protected health information about me to the following entity, person, or persons identified below for the purpose of completing leave/ FMLA paperwork.

Individual or entity name: _____
Address:_____
Email:_____Fax:_____
Phone Number: _____

The authorization will expire at the end of the calendar year of your last signature below unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration earlier than the end of the calendar year:_____. You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except when a disclosure has already been made based on prior authorization. This practice places no condition to sign this authorization on the delivery of healthcare or treatment. We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

All leave is subject to the physician's approval. A $30 form fee per form is required to be paid prior to completion of paperwork. Completed forms will be returned as requested above.

Patient signature:_____Date: _____

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