



# Medical Record and Form Completion Information

MediCopy is a health information management company that has partnered with your healthcare facility to fulfill your Release of Information requests as well as your Disability/FMLA paperwork.

## Here's What to Expect:

- 1) Sign an authorization form or turn in your Disability/FMLA paperwork at your healthcare facility.** Please provide an email address if available as this will expedite the process.
- 2) Your healthcare facility will forward your request or paperwork to MediCopy for completion.** If payment is required you will receive an invoice via email.
- 3) If you need to submit when you are not at the healthcare facility please visit [www.medicopy.net/patients](http://www.medicopy.net/patients).**

If you have any questions, please contact MediCopy

 **online chat: [MediCopy.net](http://MediCopy.net)**  
 **toll-free phone: 866.587.6274**

MediCopy is fully HIPAA compliant and adheres to all state and federal regulations regarding your protected health information.



## MediCopy Disability/FMLA Intake Form and Authorization

### Where is the form/records coming from?

Facility/Doctor's Name:

### Tell us about the patient.

Name:

DOB:

SSN: XXX-XX-

Email:

Address:

City:

State:

Zip:

Phone#:

Fax#:

### Where are we sending the completed form/records?

Name:

Email:

Address:

City:

State:

Zip:

Phone#:

Fax#:

### What would you like released?

Treating physician's name:

Time off is: (Circle one)

**Intermittent or Continuous**

Time off start date:

/ /

Estimated return to work date:

/ /

Additional information:

If you do not want certain portions of your medical records released, please check the categories listed below you would like excluded.

Substance Abuse, if any

AIDS/HIV/STDs, if any

Psychological/Psychiatric conditions, if any

### Why are we sending the completed form/records?

Purpose of Disclosure \_\_\_\_\_

### Patient's Signature

I hereby authorize MediCopy and its affiliates to release or disclose to the person(s) or organization listed above, all medical records requested, including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia or HIV infection, *unless otherwise noted*. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the recipient on this request and will no longer be protected by federal regulations.

Patient's Signature:

Date:

Relationship to patient: