UCBC | UHA
UNIVERSITY CANCER & BLOOD CENTER
UNIVERSITY HEALTH ALLIANCE

Docfluent

FMLA/DISABILITY INTAKE & AUTHORIZATION

TELL US ABOUT THE REQUEST:			
Request Date:	Document Type: ❑ FMLA ❑ Disability ❑ Other:		
Requestor Name:	Relationship to patient: ❑ Self ❑ Other:		
Purpose of Request:			
Start Date:	Return Date (est):	Type of Leave:	❑ Intermittent ❑ Continuous
Restrictions:			

TELL US ABOUT THE PATIENT:		
Name:	DOB:	SSN:
Address:	City/State/Zip:	
Preferred Phone #:	Type: ❑ Home ❑ Cell ❑ Work	Best Time to Call: ❑ AM ❑ PM
Email:	Treating Physician:	

SEND COMPLETED FORM(S) AND/OR RECORDS TO:		
Company Name:	Attention:	
Address:	City/State/Zip:	
Phone:	Fax:	Email:

AUTHORIZATION AND ATTESTATION

I hereby authorize University Cancer & Blood Center 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, HIV, or STDs, unless otherwise noted. This authorization is valid for 12 months from the date of signature. I understand that I may cancel or revoke this authorization at any time in writing, but any information released prior to University Cancer & Blood Center receiving cancellation will not be affected. 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.

I understand the turnaround time for completion of this request is 10 business days. I further understand that University Cancer & Blood Center is not responsible for technical issues resulting in unsuccessful or delayed transmission of documentation. Upon request, a copy of completed forms and supportive documentation can be made available via secure email. If email is not an option, arrangements can be made for pick-up by the patient and/or authorized representative on file.

Requests for completed documentation can be made by contacting Docfluent by phone at 512.298.1843 or by email at fmla@docfluent.com

X _____ _____ _____

Signature of Patient/Authorized Representative | Please Print Name | Date

Relationship to Patient: ❍ Patient (self) ❍ Parent (of a minor patient) ❍ Legal / Court-Appointed Guardian ❍ Healthcare Power of Attorney

FOR OFFICE USE ONLY			
Received By:	Location:	Date:	Time: