Short-Term Disability and FMLA Authorization

Patient Name: ______________________________

DOB: ________________________

Address: ____

____

Phone: ________________________

Fax: _________________________

Start and end dates for leave: ______________________________________

This form will serve as an authorization for Athens Healthcare for Women to release my records to my employer and/or any disability companies relative to my Short-Term Disability or FMLA benefits.

Patient Signature: ____________________________________

Date: ____________________________