has partnered with:

for your FMLA & Short-Term Disability Form Completion Needs!

Sharecare is committed to providing the highest levels of Quality, Professionalism, Integrity, and Responsiveness.

To initiate your Request, please complete each section of Request for Form Completion Authorization. This form will be delivered promptly to a Sharecare representative for processing.

For questions or status inquiries, Contact Sharecare Customer Care:

866-273-4039

Dear Patient,

Thank you for contacting **OBGYN Associates of Des Moines** Release of Information Department. We are here to serve you and your health information needs.

For FMLA or disability leave paperwork, please complete the enclosed authorization form, and attach your blank Form for completion.

- Please make sure you have *specific* instructions included as to where you are requesting the Form to be sent after completion.
- Leave will only be certified based on your treatment plan while under the care of OBGYN Associates of Des Moines.
- You may elect to have completed Form emailed, mailed, or faxed to the recipient listed. **It is recommended that you elect to receive your Form back via email.**
- **Please be aware that you are authorizing the release of protected health information to supplement your FMLA/disability leave claim.** This means records may be attached to the Form that are being completed and will be released as indicated on the authorization.

Return the completed release and blank FMLA/Disability Form to:

Fax: (515) 288-3200

Mail: **OBGYN Associates of Des Moines**
Attn: Medical Records/ROI
330 Laurel Street, Suite 1100
Des Moines, IA 50314

A fee of $35.00 per form is required prior to form completion. For each consecutive or subsequent form regarding the same qualifying condition and claim, a $35 fee will be assessed, plus any applicable state tax. You will be contacted by Sharecare with payment options after you return this paperwork to your provider.

Once payment is received, your form will be completed and sent to the recipient listed on your release. For questions pertaining to FMLA or disability leave paperwork, please contact Sharecare at 866-273-4039.

Again, thank you for allowing us to serve you.

Sincerely,

Sharecare
Trusted Partner of OBGYN Associates of Des Moines

Date: ____/____/__________

Request for Form Completion

Phone: (866) 273-4039 | Fax: (515) 288-3200

Pre- Payment is Required. Please allow 5-7 business days for completion of form(s).

A fee per form is due prior to completion of the form(s).
The fee schedule is as follows:
$35 for initial form, $35 for updates for same qualifying condition, plus any applicable sales tax.
You will be contacted by Sharecare with payment options after you return this paperwork.

What is your relation to the patient? ☐ I am the Patient ☐ I am a Family Member-Name:______________________________

Patient Name:____
(Last) (First) (Middle / Maiden)

Address:____

City:______________________ State:______________ Zip:______________

Social Security #: _______-_______-__________ Date of Birth: ______/ ______/ __________

Telephone #: _________/ _________/ ____________

Email Address(*Required)-:____

Physician:______________________ **Body Part:**______________________

Date Injury/Problem Began:______________ **Last Day Worked:**______________

For Patients requesting leave for themselves, what is the date(s) that you anticipate returning to work:______________

Please check a reason: ☐ Continuous Leave ☐ Surgery and Post-Op Treatment ☐ Intermittent Leave

For Family Members requesting leave, what date(s) do you anticipate being out of work:______________________

I authorize OBGYN Associates of Des Moines to release the completed form(s) and/or the use and disclosure of my individually identifiable health information to:

Name/Organization:____

Address:____

City:______________________ State:__________ Zip:______________

Telephone #: _________/ _________/ ____________ Fax #: _________/ _________/ ____________

Email Address: ____

Please check your preferred method of release:

☐ Email the form to the above email address
☐ Mail the form to the patient's address
☐ Mail the form to the Name/Organization above
☐ Fax the form to number provided above

I understand that: I may refuse to sign this authorization and that it is strictly voluntary. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Unless otherwise revoked, this authorization will expire on the following date, event or condition: ______________ **If I do not specify expiration this authorization will expire in 90 days.** If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by Federal Privacy Regulations and may be disclosed. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I can request a copy of this form after I sign and date it. I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information. * __________(Please Initial)

Signature:____ Date:______________________
(Patient or Authorized Representative – Relationship: ☐ Spouse ☐ Parent ☐ Other:____________________)

Revised: 9/24/2024