Brown Clinic P.L.L.P.
Personal Care From The People You Know And Trust.

Form Completion Request

SCANNED / FAXED BY: _____ TODAY'S DATE: _____

Brown Clinic PLLP
506 First Ave SE
Watertown, SD 57201

We are pleased to assist you in completing your Disability and FMLA forms. Be advised there will be a 10 business day processing time frame, as well as a processing fee based on the type of form.

We understand you may have an urgent deadline for your paperwork and will do our best to accommodate; however, all paperwork will be processed in the order that we receive it without exception. If you would like a copy of the form for yourself, please contact **Brown Clinic.**

By law, we are required to have you provide us with a signed authorization giving your permission to disclose your information. By completing the form below, you are authorizing disclosure of your private health information.

***Patient's Name** *(First, Middle Initial, Last)* _____

***Date of Birth** _____ ***Preferred Daytime Phone Number** _____

OK to Leave a Detailed Phone Message? ☐ ☐ **Yes** ☐☐ **No** **Email Address** _____

☐ **Disability Forms** ($25) - Pay to the order of Brown Clinic
☐ **FMLA Forms** ($25) - Pay to the order of Brown Clinic
☐ **Other Forms** ($25) - Pay to the order of Brown Clinic

Date of symptoms onset _____ **First day unable to work** _____ **Length of expected leave** _____

***Name of company or employer to receive form:**

COMPLETE ADDITIONAL COPY OF THIS FORM FOR EACH FORM REQUESTED.

Name _____

Address _____

Fax _____

*****Attach this form to the document to be completed for disability determination.**

I authorize **Brown Clinic** to provide charts, notes, x-rays, operative reports, lab and medication records, and all other medical information about me, including medical history, diagnosis, testing, test results, prognosis and treatment of any physical or mental condition including: any disorder of the immune system, including HIV, AIDS, or other related syndromes or complexes; any communicable disease or disorder; any psychiatric or psychological condition, including test results; any condition, treatment, or therapy related to substance abuse, including alcohol and drugs; and any non-medical information requested about me, including things such as education, employment history, earnings or finances, return to work accommodation discussions, or evaluations and eligibility for other benefits or leave periods including, but not limited to, claims status, benefit amount, payments, settlement terms, effective and termination dates, and plan or program contributions.

I also acknowledge I am responsible to pay the form completion fee prior to form completion.

Signature _____ **Last 4 Digits of Your SS#** _____

Write your full name

☐ I electronically sign this document and agree to the terms and conditions and that the above information is accurate. Further, I verify my identity through this electronic signature.

☐ **Signed Release on File**

☐ **I Approve this Form Completion**

Provider / Designee Signature _____

**Indicates Required Field*