Hill Country OB/GYN Associates
9805 Brodie Lane, Austin, TX 78748
Office: (512) 462-1936 Fax: (833) 448-3184

FMLA/Disability Authorization

Dear Patient,
Thank you for contacting Hill Country OB/GYN Associates Release of Information Department. We are here to serve you and your health information needs

For FMLA or disability leave paperwork, please complete the 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 Hill Country OB/GYN Associates.
- 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 being completed and will be released as indicated on the authorization.

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

Fax: 833-448-3184
Mail: Hill Country OB/GYN Associates
Attn: Medical Records/ROI
9805 Brodie Lane
Austin, TX 78748

A fee of $30 per form is required prior to form completion. For each consecutive or subsequent form regarding the same qualifying condition and claim, a $15 fee will be assessed. You will be contacted by Sharecare Health Data Services with payment options after you return this paperwork to you 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 Health Data Services at 866-273-4039.

Again, thank you for allowing us to serve you.

Sincerely,

Sharecare Health Data Services
Trusted Partner of Hill Country OB/GYN Associates

sharecare | HEALTH DATA SERVICES

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FMLA/Disability Authorization

Patient Information:			
Patient Name:		DOB:	
Phone:		Email:	

Return Forms:	
☐ Fax:	
☐ Email:	
☐ Mail:	
☐ Pick Up – Brodie Office	
☐ Pick Up – Dripping Springs Office	

I have read and understand the information given to me regarding form completion for FMLA/Disability.

Patient Signature: _____ **Date:** _____

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