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Bone Density Center

REQUEST FOR FORM COMPLETION

Effective 11/1/2016, a $20.00 fee is charged for completion of each disability/insurance form. Payment is due at the time of your request. Forms are normally completed in 7-10 working days.

Today's Date: _____

Patient Name: _____Date of Birth: _____

Paperwork requested from: _____

Dates of disability: _____ to _____

If applicable, date of surgery: _____

Authorization to release information: I hereby authorize "ELOA" to release and disclose to the above named company such health care records and information concerning my current medical condition as is necessary to determine my fitness for employment. This authorization shall be valid for two (2) years from the date shown below, unless revoked by me in writing at an earlier date. Although, I understand that I may revoke this authorization in writing at any time. I also understand such revocation will not apply to any information that has already been released in reliance on this authorization.

Patient Signature:_____Date:_____

Return method: ☐ patient pickup, phone # to contact when forms completed: _____

☐ mail to: _____

☐ fax to: _____

******Office Use Only******

Acct#:_____ Physician: _____

Of forms to be completed: _____ Amount paid: _____

Payment method _____Cash #_____Check _____Credit/Debit Card