Marietta OB-GYN Affiliates, P. A.

699 Church Street, Suite 220, Marietta, GA 30060

phone 770.422.8505 fax 770.693.7387 or 844.289.8257

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

Patient Name (print): ________________________________

DOB: ____

Address: ____

____

Phone number: _____________________________________

I authorize Marietta OB-GYN Affiliates, P. A. to disclose the following medical information for the purpose of FMLA and/or Medical disability leave.

Information to be disclosed:

- ☐ Maternity records Estimated Due Date ____________________
- ☐ Office notes and Operative report Date of surgery ____________
- ☐ Intermittent leave Please explain: ________________________

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This information is to be disclosed to: _____________________________________

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Patient Signature: ________________________________ Date: ________________