1230 East Main Street
Mankato, MN 56002

Disability/FMLA/Illness Release of Information

Patient name: ____________________________ Date of birth: _________________________

Address: ____

Phone Number: Home: ________________________Work:___________________________

Physician name to complete form: ____

Reason for Disability/FMLA/Illness

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Dates of disability: From _____________Thru_________________

Return completed Disability/FMLA form to:

You the Patient ________ Your Employer________ Insurance Co________

If your paperwork is denied; you will be notified. No forms will be returned.

If form is to be returned to your Employer or Insurance Company please list their name and address below:

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Fax Number:________________________________

I hereby authorize the above listed physician at the Mankato Clinic to furnish all information that may be requested concerning my illness, injury, medical history, consultation, prescriptions or treatment relating to this disability to the above listed parties. This authorization is valid for 1 year from date of signature.

Patient signature: ____ Date: _______________

MC1553 (08/14)