

## FORM COMPLETION REQUEST

Disability Benefits FMLA / Family Caregiver Return to Work

X \$25.00 = Request and Pay Online https://AskForRecords.com/Nash
Patient First Name Patient Last Name Patient Date of Birth Patient Last 4 of SSN
Your First Name (if not the patient)  Your Last Name (if not the patient)  Relationship to Patient
Treating Physician  Body Part Injured  // / / / / / / / / / / / / / / / / /
Please provide your email address and phone number for important notifications about this request:  Email Address  Phone  Preferred Method
How would you like the completed form delivered?  ○ Securely delivered to you electronically (You must enter an EMAIL ADDRESS or MOBILE PHONE above)  ○ Faxed ⇒ Name / Company Fax Number  ○ Mailed ⇒ □ Use insurance company address on form  Alternate Address  City State Zip
I am authorizing Nash OB-GYN Associates, P.A. to release any required health/medical record information, and/or work status/ return to work information to my employer/disability insurance carrier/FMLA administrator, accident policy carrier on my behalf as indicated by my signature below.  Signature  Date



Nash OB-GYN has partnered with RecordQuest to collect payments, complete forms, and provide status updates. You may receive communications from RecordQuest during the form completion process. Any information you share is used strictly to fulfill your request.