



Pre-payment of the \$20 fee is required prior to completion of requested form(s). Please allow **1–3 business days** for processing after all required information and payment are received.

You will be contacted by FillBetter with available payment options after submission.

Patient Information

Relationship: Patient Family / Representative Name: _____

Name: _____ **DOB:** _____ **Sex:** M F

Patient ID / Acct #: _____

Address: _____

City: _____ **State:** _____ **ZIP:** _____

Phone: _____ **Email:** _____

Treating Physician: _____

Diagnosis / Problem: _____

Body Part: _____

Date Condition Began: _____ **Last Day Worked:** _____

Expected Return Date (if known): _____

Leave Type: Continuous Surgery / Post-Op Intermittent

Release & Delivery

I authorize release of completed form(s) and related health information to:

Recipient Name / Organization: _____

Address: _____

City: _____ **State:** _____ **ZIP:** _____

Phone: _____ **Fax:** _____

Email: _____

Delivery Method: Mail to Patient Mail to Recipient Fax Secure Email

Authorization

I authorize FillBetter to coordinate completion of the requested form(s) with my medical provider and to release completed forms and related health information to the recipient listed above. I understand that completion is based on medical records and provider discretion, that payment may be required prior to processing, and that this authorization may include sensitive health information and may be revoked in writing at any time.

Signature: _____ **Date:** _____

Printed Name: _____