Ottawa County FOC - Health Care Provider Statement

CLIENT SECTION

(complete section and give form to your health care provider)

Docket/Case Number(s): ____

I, ____(print name), ____________(DOB) authorize my health care provider to release the following medical information to the Ottawa County Friend of the Court and provide updates upon request. Unless otherwise revoked, this authorization will expire one year after my signature.

________________________________ Signature

________________ Date

HEALTH CARE PROVIDER SECTION

(Please print legibly and complete all questions)

Patient Diagnosis:____

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1) Date of last visit:________________________ Date of Next Visit:______________________
2) Patient’s current ability to work:
   - ☐ Patient may continue regular work duty and has no medical restrictions.
   - ☐ Patient is able to work with restrictions(explain restrictions on hours/types of work below)
   - ☐ Patient is temporarily unable to work(explain duration below)
   - ☐ Patient is permanently unable to work.
3) Patient’s ability to work has been impacted in this way since: ____________________(Date)
4) Patient's ability to work is expected to be impacted in this way through: ______________(Date)

Additional Comments: ____

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I CERTIFY THAT I AM A CURRENT TREATING LICENSED MEDICAL PROFESSIONAL FOR THE ABOVE NAMED INDIVIDUAL AND THE INFORMATION ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

________________________ Signature

__________ Date

________________________ Agency/Office Name

________________________ Printed Name

________________________ Email or Address(for follow-up updates if allowed upon FOC Request)

Return Instructions – please email to foc@miottawa.org (preferred) or fax to 616-846-8128

Office Use Only Below This Line