

Physician's Statement

Patient's Authorization to Release Information:

This form, signed by me, authorizes the release of any and all medical information/records to American Traveler and affiliates and/or any of its client hospitals or institutions which are relevant to my employment. Under company policy and federal law, personnel who obtain access to health information and medical records as part of employment records may use the information for purposes only permitted by law.

Signature:	Date:
Print Name:	
Social Security Number: Statement of Health To be completed by a Physician The above named patient has been examined by me and found to be in good physical and mental health, free from communicable diseases and able to function at full capacity.	
Print Name:	Title:
Office Address:	
City/State/Zip:	
License Number:	
Phone Number:	
Fax Number:	Revised 04/2009