American Traveler®

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.

Physician's Signature: _____ Date: _____

Print Name: _____ Title: _____

Office Address: _____

City/State/Zip: _____

License Number: _____

Phone Number: _____

Fax Number: _____

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