	HEALTH CARE PROVIDER STATEMENT	**CASE NO: (List all)**

Friend of the Court Address:
219 E. Paw Paw Street, Paw Paw, MI 49079
Email: **foc@vanburencountymi.gov**

Telephone No:
(269) 657-7734
Fax No: **(269) 657-8282**

Patient Last Name	First Name	Date of Birth	Phone Number

Address	Email

I authorize _____ to release the following medical information to the
(Name of the health care provider)
Van Buren County Friend of the Court. I understand that if I give permission, I have the right to change my mind and revoke it, in writing. I also understand that any use or disclosure already made with my permission cannot be taken back. Unless otherwise revoked this authorization will expire one year after my signature.

_____ _____
Patient Signature Date

TO BE COMPLETED BY: Health care provider (such as your doctor)

1. Date the patient was last seen: _____

2. What is the patient's diagnosis? _____

3. What is the patient's prognosis? _____

4. Is the patient able to work?

☐ Yes, the patient can work with the following restrictions: _____

☐ Yes, the patient can work without restrictions. ☐ No, the patient is unable to work.

5. If the patient is unable to work, for what period of time?

☐ From: _____ (Date) Until _____ (Date) ☐ At least until _____ (Date)

☐ Long-term disability with no expectation of future ability to work.

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Comments:

_____

Health care provider signature: _____ Date:_____

Health care provider printed name: _____

Address: _____

_____

_____

Phone Number: _____

Email Address: _____

Return this form to: Van Buren County Friend of the Court
219 E. Paw Paw Street
Paw Paw, MI 49079

Or Fax: 269-657-8282

Or email: foc@vanburencountymi.gov