Health Care Provider Statement

Return this form to:

Friend of the Court
PO Box 351
Grand Rapids, MI 49501-0351

or fax: 616-632-6871
or email: foc.mail@kentcountymi.gov

Name: _____ Date of birth:_____
Case # (all):_____
_____
Social Security #:_____ Phone #:_____
Address where you get mail:_____
_____
Email address:_____

Forms are also available online at https://www.accesskent.com/Courts/FOC/pdfs/Health_Care_Provider_Statement.pdf

****Please list any form of income (disability, work comp, SSA, etc) or advise how you are currently supported:**

_____

I authorize_____ (name of health care provider) to release the following medical information to the Kent 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**

Please have your health care provider (such as your doctor) complete the rest of this form.

Is this patient able to work?
☐ With these restrictions_____
☐ Without restrictions
☐ Unable to work

For what period of time:
☐ From ___/___/_____ until ___/___/_____
☐ At least until ___/___/_____
☐ Long-term disability with no expectation of future ability to work

Comments:_____

_____

Health care provider name _____Signature _____

Health care provider phone number_____ Address_____

Today's date _____ Date patient was last seen_____

KCFOCENF12 (8/1/2018) jam