Annual Health Statement

Patient Name: _____

The above patient has been examined by me and has been found to be in good mental and physical health, free of communicable disease, and able to function in the healthcare profession without any physical limitations.

Date of Exam: _____

PROVIDER'S PRINTED NAME: _____

TITLE OF PROVIDER (PLEASE CIRCLE ONE): MD, DO, NP, PA

PROVIDERS SIGNATURE: _____

License Number: _____

Office Phone Number: _____

I authorize my physician to release my health records to Registry Network. I realize that Registry Network, Inc. will release my health records to client facilities as a condition of placement.

Employee Signature: _____ Date: _____

Form Updated 10/29/2020