Trusted Choice Homecare

PHYSICIAN'S STATEMENT AND CONSENT TO RELEASE

Name		Phone	
Address			
City, State and Zip		Date	

I, _____, do hereby authorize release to Trusted Choice Homecare any information acquired related to my medical history.

_____ (Signature)

_____ (Date)

Attach Documentation or Fax Results to our Compliance Department (1-716-235-1755):

Annual TB Skin Test (PPD): Date Given: _____ Time Given: _____
Date Read: _____ Time Read: _____

Result: _____ MM Circle: **Negative** **Positive**

Chest X-Ray Date and Results (If Applicable/Positive PPD): _____

MMR Vaccination - Proof of Vaccination or Positive Titers of all Three Components

Vaccination Dates: #1_____ #2_____

OR

Mumps Titer: Date: _____ Result: _____

Rubella (German Measles): Date: _____ Result: _____

Titer Rubeola (Measles) Titer: Date: _____ Result: _____

Statement from Physician/Qualified Health Provider (to be completed by MD, DO, NP or PA):

The patient above has been examined by me and found to be in good physical and mental health, is free of any communicable diseases, and is able to function in full capacity.

Physician Signature: _____ **Date: _____**

Physician Name: (Please Print): _____ **Phone: _____**

Physician Address: _____

Stamp Required