Lifetime Health medical group

Form Completion Request

Purpose of Form (Please indicate the outcome you wish to see):

For DBL Forms: 1st Day Off:_____ Est. Return to Work Date:_____

Date Form is Needed: * **Please note that it may take up to 7 business days to complete your form.**

Name of Patient:

Address of Patient:

Patient's Date of Birth:

Patient's Contact Numbers:

(Home)	(Cell)	(Other)

Please Check the Delivery Option Below:

☐ Mail Completed Form To: _____

_____

_____

☐ Fax Completed Form To: _____
(Fax Number) (Attention To)

☐ Call When Form Completed: _____
(Phone Number)

I herby authorize Lifetime Health Medical Group to release any of my medical information that pertains to the processing of my requested form.

PATIENT SIGNATURE _____ DATE_____