Family Adoption Services
2010 Lancaster Road
Birmingham Alabama 35209
(205) 414-6003

MEDICAL DISCLOSURE AUTHORIZATION

Dr. ____,

You are hereby authorized and requested to furnish and release to Family Adoption Services or any representative thereof, a statement regarding my mental or physical condition and capacity to care for a child. Please give all requested information in the space provided below.

____
Signature of Patient   Date

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____
Full Name of Patient   Date of Birth

____
Address

I. GENERAL MEDICAL FINDINGS

History ____

____

Height	
Weight	
Pulse	
Respiration	
Blood Pressure	
General Appearance	
Eyes-Vision	
Ears-Hearing	
Nose, throat, sinuses	
Heart	
Lungs	
Genital-Urinary and Gynecological	
Abdomen	
Extremities	
Nervous System	

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II. LABORATORY FINDINGS (These tests are *REQUIRED* in accordance with agency and State DHR minimum standards for the placement of children; the serology, TB and HIV screens are not optional. Please indicate result and date of result.)

Urinalysis	
CBC if indicated	
Serology (RPR or VDRL)	
Intradermal Tuberculin Test (Mantoux)	
HIV Screen	
Any Special Procedures, if indicated	

III. To the best of your knowledge, has this patient ever undergone treatment and/or therapy for any emotional/mental/psychological condition? If so, please state when and describe fully.

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IV. On the basis of your examination and knowledge of this person, do you believe his/her physical, mental and emotional condition is such that he/she is able to take on the care and responsibility of a child?

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____

Signature of Physician Date

____

Address

When completed, please return to:
FAMILY ADOPTION SERVICES
2010 LANCASTER RD
BIRMINGHAM, ALABAMA 35209
(205) 414-6003