Medical Release Opinion / Release of My Medical Information:

Driver's / Patient Name: _____Date of Birth: _____

Signature: _____ Date: _____

Name of Treating Physician / Clinic: _____ Patient's Date of Last Office Visit: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

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1. **Medical Condition**: _____

2. **Date of Onset, Diagnosis:** _____

_____

3. **Course of Treatment.** (Medication, Rx, OTC, supplements etc) _____

_____

4. Has treatment be shown to be adequate, effective and safe? Yes _____ No _____

_____

5. Is the drivers condition stable enough for to work as a Commercial Motor Vehicle Driver? Yes __ No__

If no, then when: _____

6. Is the driver released to operate a Commercial Motor Vehicle? Yes _____ No _____

I have read and/or understand the job description of a commercial motor vehicle driver.

Signed or stamp from Treating Physician: _____ Date: _____

Please let my signature act as my request for the release of my medical information to:

Joseph H. Lones III, DC
Certified DOT Medical Examiner
North Lamar Chiropractic Center
10102 North Lamar Blvd.
Austin, TX 78753

(512) 835-1955
(512) 835-4424 (FAX)
NorthLamarChiropractic@gmail.com

The above mentioned Driver / Patient is preparing to take a Federal Motor Carrier required DOT Physical Examination in order to obtain a Medical Certification to operate a commercial motor vehicle.

In order for the Certified Medical Examiner to complete the DOT Physical Examination, certain information is needed from you (the treating physician), about any medical condition for which you have been treating this patient.

Please complete the Medical Released Opinion Form letter enclosed, and FAX to the requesting DOT Certified Medical Examiner, or give a copy to the requesting Driver / Patient

Please Complete and FAX back to Certified Medical Examiner (512) 835-4424