AMERICAN ALLIANCE
CASUALTY COMPANY

Chicago, Illinois
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PHYSICIAN/OPTOMETRIST REPORT

NAME OF DRIVER WHOM THIS FORM IS BEING COMPLETED FOR		
NAME OF POLICYHOLDER HOLDER IF DIFFERENT FROM ABOVE		
POLICY#	PRODUCER	PRODUCER#
ARE THERE ANY RESTRICTIONS CURRENTLY APPEARING ON YOUR DRIVERS LICENSE? IF YES, PLEASE EXPLAIN		

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

This authorization permits you (the attending physician and/or optometrist) to provide all information you may have regarding my condition while under your observation of and/or treatment. You are authorized to provide this information to be used for the underwriting of automobile liability insurance. **NOTE: The policyholder/applicant, not the insurance company is required to pay fees for completion of this form.**

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SIGNATURE OF DRIVER FOR WHOM THIS REPORT IS BEING COMPLETED FOR DATE

THE BELOW IS TO BE COMPLETED BY PHYSICIAN AND OR OPTOMETRIST

NATURE OF IMPAIRMENT OR ILLNESS

DURATION OF IMPAIRMENT OR ILLNESS

MEDICATION (TYPE(S) AND AMOUNT)

IN YOUR OPINION, WILL THE IMPAIRMENT OR ILLNESS OR PRESCRIBED MEDICATION ADVERSELY AFFECT THE ABILITY OF THE DRIVER LISTED ABOVE TO SAFELY OPERATE A MOTOR VEHICLE? IF YES PLEASE EXPLAIN.

PLEASE CIRCLE THE APPROPRIATE STRENGTH THAT REFLECTS THE ABOVE LISTED DRIVER

RIGHT EYE	20/20	20/30	20/40
LEFT EYE	20/20	20/30	20/40

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PHYSICIAN'S OR OPTOMETRIST NAME (PRINTED) _____

PHYSICIAN'S OR OPTOMETRIST SIGNATURE_____

DATE_____