Medical Release of Information

I, Enter Employee Name, hereby release my treating physician, Enter Physician Name, to provide my employer pertinent information about my current work-related injury/illness, and how that injury may affect my ability to perform the essential functions of my job. No other confidential information may be released without my written consent. This release will be valid no longer than 90 days, at which time it will be re-evaluated. Any medical information obtained will only be used in the return to work program, and there will be no release on medical information form the employers file.

Employee Signature: _____ Date: _____

Employer Signature: _____ Date: _____

Employer Print Name: _____ Title: _____