**AUTHORITY TO RELEASE MEDICAL INFORMATION**

(Employee Name )

(Employee Address)

(Date of Birth)

I authorize (name of treating doctor) to release medical information to my employer, (name and address of employer), regarding my on the job injury that occurred on (date of injury). This information is confidential and may not be used for any purpose other than facilitating the claimant’s return to work.

This information may facilitate my return to medically appropriate productive work.

Print Employee Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: (Today’s Date)