MEDICAL AUTHORIZATION

TO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Physician Name)

You are hereby authorized and requested to furnish my employer, , its agents or representatives, any and all information, as requested by the enclosed Certification of Health Provider form, regarding my physical or psychological condition, or regarding any injuries or disease for which I have consulted you or received your services, as they relate to my ability to perform the essential functions of my job. This authorization includes the release of information regarding the nature of the physical or psychological impairment, history, contributing factors, complications, estimates of the period or amount of disability, subjective symptoms, objective symptoms, diagnosis and prognosis. Please return the completed form in an envelope marked “Confidential” to:

**Teena Canfield, Human Resources Director**

**Windsor Southeast Supervisory Union**

**105 Main Street, Suite 200**

**Windsor, VT 05089**

A photostatic copy of this authorization shall serve in its stead.

PATIENT

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address

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Witness Date

*348-, 4533 am*