

Wilson County School  
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## Sick Leave Bank

### AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION TO BE COMPLETED BY PATIENT AND RETURNED

Name:

Address:

Date of Birth:

EE #:

**AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize the undersigned physician to release any information acquired in the course of my examination or treatment.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

### TO BE COMPLETED BY PHYSICIAN

Physician's Name (print):

Phone #:

Address:

Brief description of illness (layman's language please):

If still disabled, date patient should be able to return to work:

Patient was under my care and unable to work from (date): \_\_\_\_\_ to (date): \_\_\_\_\_

Signature of physician: \_\_\_\_\_ Date: \_\_\_\_\_

PLEASE RETURN TO PATIENT FOR SUBMISSION WITH SICK LEAVE REQUEST FORM

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