## **Employer Occupational Health Medical Release Form**

## **Employee Information**

| Employee Name                    |
|----------------------------------|
|                                  |
| Employee ID                      |
|                                  |
|                                  |
| Department                       |
|                                  |
| Job Title                        |
|                                  |
|                                  |
|                                  |
| Medical Provider Information     |
| Provider Name                    |
|                                  |
|                                  |
| Provider Phone                   |
|                                  |
| Provider Address                 |
|                                  |
|                                  |
|                                  |
| Release Information              |
| Release information to           |
|                                  |
| Dumana of Dalacca                |
| Purpose of Release               |
|                                  |
| Information to be Released       |
|                                  |
|                                  |
|                                  |
| Authorization                    |
|                                  |
| Employee Authorization Signature |
|                                  |
| Date                             |
|                                  |