COMMUNITY LIVING-CENTRAL HURON
PO Box 527, 267 Suncoast Dr. E.
Goderich, Ontario N7A 4C7

Early and Safe Return to Work Program

Medical Release

Employee Name: _____

My signature on this letter is authorization for my doctor, named below, to release information including, opinions, assessments or reports concerning my medical conditions to Community Living-Central Huron and to discuss the pertinent details of my case with the designated representative of Community Living-Central Huron. A photocopy of this signed authorization shall be valid as the original.

Doctor's Name: _____

Address: _____

_____

Phone #: _____

Fax #: _____

_____ _____

Signature of Employee Date

Copy To: Administrative Coordinator, Community Living-Central Huron.