## MEDICAL CONSENT FORM

| **Employee Information** | | |
| --- | --- | --- |
| Employee Name: | | |
| **Organization Requesting the Information** | | |
| Organization Name: | | |
| Contact Name: | | |
| Email: | | |
| Phone Number: | | |
| **Name of Medical Professional** | | |
| Insert Name: | | |
| Insert Contact Information: | | |
| **Purpose of Disclosure** | | |
| [Organization Name] is requesting ONLY the following information:   * information that is related to the employee’s ability to perform their job duties (a job description will be included with the request for medical information) * medical information confirming that the absence is for medical reasons * an approximation of the date the employee is expected to return to work (if known)   This consent relates only to the operation of the workplace and job duties, and is relevant to the time period of the absence.  This request does not permit any disclosure related to an employee’s diagnosis or additional confidential medical information. | | |

I hereby authorise the health professional named above to disclose the above-described health information to the organization indicated herein. I understand why I have been asked to disclose my health information and how it will be used. Additionally, I am aware of the risks and benefits associated with consenting or declining to consent. I understand that I have the right to revoke this consent in writing at any time.

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(Employee Signature) (Date signed)