City of Auburn, Maine

General Assistance Office
Jeff Tardif, Manager
60 Court Street | Auburn, Maine 04210
www.auburnmaine.gov | 207.333.6601 X 1411

MEDICAL RELEASE/PHYSICIAN'S STATEMENT

Client's name: _____ DOB: ____/____/____

Client's address: _____

Healthcare Provider: _____

I hereby give me consent to the City of Auburn to receive any and all medical information from the above-named healthcare provider.

Client's Signature: _____ Date: ____/____/____

> **By Maine State Statute, any information provided is confidential.**
> **We have asked the client to return this form to us as soon as possible so we can determine their eligibility.**
> **Please return this form to the client, fax it to 207-510-8070, or mail it to the address above.**

1. Does the individual have any illness, disability, or handicap which limits his/her ability to work?
   Please explain: _____

2. Date you last evaluated this individual for this disability: ____/____/____

3. Does this illness or condition require medication? _____

4. To what extent is the individual able to work or participate in activities to prepare for work?

   The individual is able to work or participate in activities to prepare for work (job searches/workfare)

   Without restrictions: ☐ Full time (40 hours/week)   ☐ Part time at _____ hours per week

   With restrictions: ☐ Full time (40 hours/week)   ☐ Part time at _____ hours per week

   Please list any restrictions: (i.e., sitting, standing, walking, climbing stairs/ladders, kneeling/squatting, bending, pushing/pulling, lifting/carrying, or keyboarding) _____
   _____

   The individual is unable to work or participate in activities at all.
   ☐ The disability is permanent   ☐ The disability is not permanent and is expected to last _____ months.

5. In your opinion, is this client so disabled that he/she should apply disability benefits?

   If the individual is not considered permanently disabled, what can this individual do to help themselves become work ready _____

   Can this individual participate in educational/training programs? _____

6. Would you recommend any vocational rehabilitation, physical rehabilitation, or other services to help the individual? If so, what? _____

7. Is there any other information that you think would be helpful? _____

_____   _____   _____
Signature of healthcare provider   Date   Printed name of healthcare provider