



# 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 207-333-6625, 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