14225 University Ave. Suite 130
Waukee, Iowa 50263
515-252-0000
www.mysighealth.com

Authorization for Medical Release

(MUST BE completed by the student/employee)

I, _____, do hereby authorize my physician, Dr.

_____, to release my recent medical examination, to Signature Healthcare, which is relevant to my education/employment.

_____ _____
Signature Date

Office / Clinic Address

(PLEASE PRINT)

Clinic:_____

Street Address: _____

City: _____State:_____ Zip: _____

Office Telephone Number: _____ Office Fax: _____

Statement of Health

(To be completed by the Healthcare Provider)

I have examined the patient and determined that this person is in good physical and mental health, has no signs or symptoms of communicable diseases, and is able to function and perform all job duties without any physical limitations in his/her profession/education at full capacity.

_____ _____
Signature and title of Provider ***Date of Examination***

_____
Printed Name of Provider