REQUEST FOR CONFIDENTIAL MEDICAL INFORMATION

This section to be signed by the ***General Assistance Applicant***

Name	Social Security Number ___ - __ - ____
Mailing Address	
Municipality	Name of Health Care Provider
Mailing Address of Health Care Provider	

- I understand that I may refuse authorization to disclose all or some healthcare information but that refusal may result in the denial of my General Assistance application.
- I hereby give my consent to the above-named municipality to receive medical information from the above-named health care provider regarding my ability/inability to work in order to determine my eligibility for General Assistance.
- My consent to release this information is effective until _____ *(date not to exceed thirty months from date of authorization),* and I authorize subsequent disclosures regarding this information during this time period.
- I understand that I may revoke this authorization at any time by executing a written revocation and providing a copy of that revocation to the person I have authorized to release this information. My revocation is not effective until the person I authorize to release information has received notice of my revocation. Revocation of this authorization may result in the denial of General Assistance benefits.
- I understand that I am entitled to a copy of this authorization form.

_____ _____

Signature of General Assistance Applicant Date

This section to be completed by the ***General Assistance Administrator***

Name	Municipality	Telephone
Mailing Address		

This section to be completed by the ***Health Care Provider***

The above-named person has applied for General Assistance (GA) from the above-named municipality. In order to determine GA eligibility, information regarding the applicant's illness/disability preventing him/her from working must be obtained. Please answer the following at your earliest opportunity and return this form to the General Assistance Administrator listed above.

1. Does the applicant have any illness, injury, or disability that limits his/her ability to work? ☐ Yes ☐ No
2. Are there any restrictions on the kinds of work the applicant can perform, how many hours he/she can work, etc. ☐ Yes ☐ No
3. If you answered yes to #2, please explain: _____
4. Can the applicant perform the following:

	Yes	No	
• Look for work	☐	☐	
• Attend an education or training program	☐	☐	
• Work full-time	☐	☐	
• Work 20 hours or less a week	☐	☐	(If yes, how many hours _____)

Please use the reverse side, or additional paper if necessary.

5. If there are any physical or psychological limitations regarding the applicant's ability to work, how long do you expect this condition to last before he/she may work?
6. Would you recommend any vocational education, physical rehabilitation, or other services to help the applicant and if so, what?

_____ _____

Signature of Health Care Provider Date