

MEDICAL RELEASE AUTHORIZATION

Authorization

I, _____, hereby authorize Dr. _____ to release to **Urgent Medical Staffing Solutions, LLC** and any of its client hospitals or institutions any information acquired in my recent medical examination which is relevant to my employment.

Signature

Date

It is the responsibility of the applicant to have their physician complete and sign below.

***Please provide copies of results with this authorization.**

Physician's Statement

I have examined the above named individual, and to the best of my knowledge, he/she is in good physical and mental health, free of communicable diseases and is able to function in his/her profession in full capacity. By signing below I certify that the above documentation is valid.

Physicians Signature

Date

Printed Name of Physician

Name/Address/Phone # of Client/Facility