



CITY OF PROVIDENCE

Angel Taveras, Mayor

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize the physician, _____
(Please **print** the name of your physician)

to speak with Sybil Bailey, Director of Human Resources, and/or her designee, for the
purpose of obtaining medical information that involves my ability to perform the
functions of my job.

Please list:

Your Physician's Street Address, City, State, Zip Code

Your Physician's Phone Number

Employee's Signature

Date

HUMAN RESOURCES

Providence City Hall | 25 Dorrance Street, Room 401, Providence, Rhode Island 02903

401 421 7740 ph | 401 273 9510 fax

www.providenceri.com