WELFARE DEPARTMENT
424 White Mountain Highway
PO BOX 310
Milton, NH 03851
PHONE: (603)652-4501 x9 FAX: (603)652-4120

Patient Name:_____ Case #:_____
Address:_____ DOB:_____
_____

I hereby request the release by a doctor, hospital or clinic to the Milton Welfare Department, or its authorized representative, any information regarding my medical diagnosis, medical history, treatment plan or hospitalization. A photocopy of this signed release may be used in place of an original, in effect for six months from the date of my signature below.

_____ _____
APPLICANT SIGNATURE DATE

TO THE PHYSICIAN OR CLINIC:

The person named above has indicated that he/she is currently unable to work and is in treatment with you. New Hampshire General Assistance laws require able-bodied welfare applicants to seek and retain work as a condition of continued assistance, with the goal of minimizing the period of assistance necessary. The Town of Milton also may require welfare recipients to work in any capacity that the recipient is able in exchange for assistance. For these reasons, will you please briefly respond to the following questions:

Physician:_____
Address: _____
_____

Is this person disabled? _____ NO _____ YES (If Yes, please check below)
_____ Temporarily _____ Permanently
_____ Totally _____ Partially

Date incapacity started: _____ Expected to end:_____

Can this person do ANY form of work? _____ NO _____ YES (If Yes, please check below)

_____ Light duty work _____ No restriction
_____ Full-time work _____ Part-time work

Restrictions:_____
_____

If disabled, please place diagnosis in order of importance:

1.
2.
3.
4.

Medications prescribed: _____
_____
Are any of these medications required to sustain life? If so, Which ones: _____
_____

_____ _____
SIGNATURE OF PHYSICIAN DATE

Please return via fax or mail to the office listed above