



Authorization for Release of Medical Information for Accommodations

To: _____				
Name of Medical Provider				
Street Address	City	State	Zip Code	Telephone
Re: _____ / _____				
Name of Patient			Date of Birth/Social Security Number	
Street Address	City	State	Zip Code	Telephone

I hereby authorize _____ to
(Name of Medical Provider)
disclose to Stephanie A. Miller, Director of Human Resources, or any other person, including the agency's legal counsel, who is authorized by my employer to handle medical information for ADA purposes any information concerning my physical or mental condition, that are necessary to determine whether I have a disability and to determine whether any accommodations can be made.

I also authorize Stephanie A. Miller or any other person who is authorized by my employer to handle medical information for ADA purposes, to speak to my treating physician or health care provider directly in regards to any questions he/she may have with respect to my condition that relates to the performance of the essential functions of my job and any accommodations that may be necessary.

I understand that the requested data is for the above-mentioned purposes, and that I may refuse to provide the requested medical information. However, I understand that if I refuse to provide the information, my employer may refuse to provide reasonable accommodation.

This authorization is valid for one year from the date indicated below or upon receipt of my signed written notice to withdraw my consent. A photocopy is as valid as an original.

Signature of Patient

Date