AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, ______________________________________, am requesting consideration for a reasonable accommodation from the Department of Corrections where I am employed.

I authorize my Appointing Authority/designee to receive medical information that will allow the Department of Corrections to evaluate the disability I may have and any limitations that affect my equal employment opportunity.

I authorize the release of the following medical information, as necessary: _____________________

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I give authorization to disclose my confidential medical information solely on a need-to-know basis. This includes direct contact with my health care provider to discuss my limitations, the essential functions of my position as defined on my position description, and possible accommodations.

This authorization is valid for 90 days from the date of signature unless specifically revoked during that time. I understand that I may revoke or discontinue my authorization in writing at any time and the revocation will not affect any information already shared.

A photocopy and/or fax of this release form will be valid as an original.

________________________________ ________________
Signature Date

State law and/or federal regulations prohibit disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.

Distribution: **ORIGINAL** - Employee Occupational Health Record **COPY** - Health Care Provider