DALLAS COUNTY
HUMAN RESOURCES/CIVIL SERVICE DEPARTMENT

ADA ACCOMMODATION POLICY
AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

I, _____HEREBY AUTHORIZE,

_____
Physician's Name

_____
Street Address

_____
City/State/Zip Code

_____
Telephone Number

to release only that medical information pertinent to the accommodation needed as described on the attached request form to the Dallas County Employee Health Center physician and/or Human Resources/Civil Service Department for use in evaluating my request for reasonable accommodation. I acknowledge that I have been informed that if the medical information is not released, my reasonable accommodation may be denied.

_____ _____
Employee or Applicant Signature **Date**