Authorization for

Release of Medical Information for ADA Purposes

TO: _____

Name of Medical Provider

_____

Address

_____

City State Zip Code

RE: _____

Name of Patient/ Birth date

_____

Address

_____

City State Zip Code

I hereby authorize _____

Name of Medical Provider

to disclose to the Department of Health's agent/representative, _____, or any other person, including the Department'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 is necessary to determine whether I am a "Qualified Individual with a Disability" as defined by the ADA and to determine whether reasonable accommodations can be made.

I also authorize _____, 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 be unable to provide reasonable accommodations.

This authorization is valid for ninety (90) days from the date indicated below or upon receipt of my signed written notice to withdraw my consent. A photocopy or facsimile is as valid as the original.

_____

Signature of Patient/Employee Date