AUTHORIZATION FOR LIMITED RELEASE OF MEDICAL INFORMATION

I, _____, authorize _____ County to receive medical records and to discuss my medical condition with the following care providers:

(Please provide the full name, address, and telephone number of all applicable medical providers.)

1. _____

2. _____

3. _____

The medical records and information are limited to that which the County needs to assess my reasonable accommodation request.

I understand this is the County's attempt to obtain the following medical information (as indicated):

_____ Confirmation that my medical condition is a disability under the Americans with Disabilities Act (ADA) as amended;
_____ The functional limitations or work-related restrictions associated with the stated disability;
_____ Why the requested reasonable accommodation is needed;
_____ Clarification of medical information previously submitted to the County; or
_____ Recommendations regarding alternative accommodations.

The County will request only medical information that is directly related to the aforementioned.

I understand that the information which is collected and discussed is to be treated with confidentiality. However, directly relevant information may be shared with supervisors/managers, others who need to know to address work restrictions and/or accommodations, those responsible for emergency treatment, or those needed to provide advice on matters relating to my request for reasonable accommodation.

This Release terminates ninety (90) days after the date of the signature below.

_____ _____
Employee Date

_____ _____
Witness Date

A photocopy or facsimile of this form will serve as an original.