Authorization for Release of Healthcare Information

I, _____, DOB _____

_____ (initial) request and authorize the following professionals to release pertinent medical, psychological, educational, or vocational information regarding my disability for the purpose of determining job accommodations.

_____ (initial) also request and authorize the HR Representative to release pertinent medical, psychological, educational, or vocational information regarding my disability for the purpose of disability accommodation implementation to the professional/s listed below; and/or

_____ (initial) also authorize the professional/s listed below to speak with the HR Representative about my medical, psychological, educational, and/or vocational history, treatment, diagnosis, opinions, and other related information regarding my disability for the purpose of determining job accommodations.

_____

Licensed Professional – Signature

_____

Licensed Professional - Printed Name

_____

Affiliation (Name of office, practice, or business)

_____

Street, City, State, Zip Code

_____

Phone # Fax # Email

I understand this authorization is voluntary and I may revoke this consent at any time through a written, signed, and dated request to the HR Representative. The revocation will not apply to action taken prior to that date.

Employee Signature_____Date_____