Health Care Release Form

Accommodations Committee

Fort Worth Independent School District

The Employee Benefits Department of Fort Worth Independent School District facilitates the ***Accommodations Committee*** review of ADA accommodation requests and coordinates the consideration of internal and external resources to assist any employee who may be experiencing physical and/or mental health challenges which may affect the employee's job performance. The Committee reviews employees' requests for accommodations and recommends appropriate and reasonable accommodations in accordance with the Americans with Disabilities Act.

The employee's signature on this form authorizes written and verbal communications between the Accommodations Committee facilitator and the health care professional(s) named below. This communication will facilitate the analysis of reasonable and appropriate accommodation recommendations for the employee, and may be made by telephone, written correspondence, fax, email, or conferences. This is not a request for medical records.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II form requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by the law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information", as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or individual's family members or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

I, _____, have read the above statement and I do hereby authorize the Fort Worth Independent School District's Accommodations Committee and/or designee to communicate with the health care provider listed below by verbal or written correspondence. I authorize both parties to share any information deemed necessary to facilitate the analysis of my accommodation request and of reasonable and appropriate accommodation recommendations, as referenced or specified in the attached Medical Information Request Form and Request for Accommodation Form.

Employee's Name:_____ EID# _____

Address: _____

Social Security No._____ Date of Birth: _____ Gender:_____

Primary Phone:_____ Primary Email:_____

Health Care Provider Name (MD, DO, or Ph.D.):_____

HCP's Address: _____

HCP's Phone:_____ HCP's Email:_____

Employee Signature: _____ Date: _____

Please email or fax form to Leaves and ADA Management.
Email: leaves@fwisd.org
Fax: 817-814-2185