MEDICAL/HEALTH CARE INFORMATION RELEASE FORM

INSTRUCTIONS FOR EMPLOYEE: Complete health care provider information and sign authorization release below. Make additional copies of this form for each of your health care providers, if you have more than one provider.

HEALTH CARE PROVIDER INFORMATION

Attending Health Care Provider's Name: _____

Attending Health Care Provider's Specialty: _____

Address: _____

City: _____ State:_____ Zip:_____

Phone Number:_____ Fax Number: _____

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I have requested an accommodation from Central Alabama Community College, under The Americans with Disabilities Act (ADA) of 1990.

I hereby authorize the ADA Coordinator for CACC to communicate directly with the health care provider who completes this form, in order to obtain clarification of issues relating to the functional limitations for which I am seeking an accommodation.

This authorization will automatically end within one year from the date I sign this form.

Employee's Signature: _____ Date:_____

CONFIDENTIALITY NOTICE: Medical-related information shall be kept confidential and maintained separate from other personnel records. However, supervisors and managers may be advised of information necessary to the determinations they are required to make in connection with a request for an accommodation. First aid and safety personnel may be informed, when appropriate, if the disability might require emergency treatment or if any specific procedures are needed in the case of fire or other evacuations. Government officials investigating compliance with the ADA may also be provided relevant information as requested.