

**AUTHORIZATION FOR THE RELEASE OF MEDICAL  
INFORMATION PURSUANT TO THE REQUEST FOR  
REASONABLE ACCOMMODATION**

Name of Licensed Physician or Practitioner	Licensed Physician Phone (optional)
Name of Office, Clinic, Hospital, etc.	Medical Number
Street Address	City, State, Zip
Social Security Number	Birth Date

**TO: Any licensed physician, other licensed practitioner, hospital, clinic or other medically related facility, or United States Veterans Administration that are in the possession of medical records pertaining to:**

**Name of Employee:**

I have requested that my employer, the Department of General Services, grant me reasonable accommodation due to my diagnosed physical or mental impairment of:

I authorize you to copy and transmit to the Reasonable Accommodation Coordinator of the Department of General Services all records concerning the above-referenced impairment and to answer any questions related to this condition. A copy of my request for reasonable accommodation is attached to this release.

The authorization shall be valid for a period of 180 days after the date of my signature or earlier if revoked by me in writing to the Reasonable Accommodation Coordinator.

I hereby acknowledge I have been informed of my right to receive a copy of this authorization upon request. I further acknowledge I have been informed if the medical information covered herein is not released, my request for accommodation may be denied.

The Genetic Information Nondiscrimination Act ("GINA") prohibits employers from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information, which includes:

- 1) family medical history
- 2) any request for, receipt of or results of the employee or family member's genetic tests, counseling or services, and
- 3) genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Signature	Date
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