MEDICAL AUTHORIZATION AND RELEASE

TO WHOM IT MAY CONCERN:

Pursuant to my request for reasonable accommodation under the Americans with Disabilities Act and the Fair Employment and Housing Act, my employer is authorized to determine whether I have a physical or mental impairment which limits a major life activity, to determine what restrictions I have that impact the duties of my position and to evaluate the effectiveness of possible reasonable accommodations.

I hereby authorize and direct you, your office/practice, its Custodian of Records and/or persons in your employ to release medical information relating to my request for reasonable accommodation to my employer, in the format of the Health Care Provider Certification Form and Essential Function Guide provided by my employer (pursuant to the Medical Confidentiality Act, Civil Code Section 56, et. seq.). This medical information may be released to any authorized representative of the City and County of San Francisco bearing this release or a photocopy thereof, in order to evaluate my request for reasonable accommodation.

I do hereby request that the Health Care Provider Certification Form be completed as fully and completely as possible.

I do hereby release and hold harmless you, your organization or company, your officers, agents, employees, or independent contractors from any liability or damages, and I do hereby waive all claims or causes of action against you, your organization or company, your officers, agents, employees or independent contractors, which may result from furnishing the requested information.

This authorization to release my medical records will expire one hundred eighty (180) days after the date signed. I have been advised that I have the right to receive a copy of this authorization.

Name(print):_____

Birthdate:_____ Last 4 Digits of Social Security No.:_____

Address:_____ Phone(w): _____
_____ Phone (h): _____

Class/Title:_____ Department:_____

_____ _____
Signature Date