DEPARTMENT OF EDUCATION APPLICANT/EMPLOYEE
CONSENT & AUTHORIZATION TO RELEASE MEDICAL INFORMATION FOR REASONABLE ACCOMMODATION

IMPORTANT: This consent and authorization deals with the release, sharing, disclosure, and receipt of your protected medical and health care information, records, and reports, *including confidential records and reports*. Please read it carefully.

I, _____, whose date of birth is_____, hereby consent and authorize _____ (Physician or medical practitioner) to release and send to the Department of Education Civil Rights Compliance Office the following information:

_____
_____
_____
_____
_____

Physician's
Name:_____
Address:_____
_____
Phone:_____

I understand this information is to help determine the extent of my disability, its effect on work activities, and any need for reasonable accommodation to enable me to perform my job in the workplace. I have read the above and fully understand its contents in its entirety and am satisfied with the reason and purpose for which my permission is given. I further understand that the Civil Rights Compliance Office may have to share information that is acquired pursuant to my request to other administrators in the event reasonable accommodations need to be processed.

My consent is valid until such time that I terminate, in writing, such consent. I understand that I can revoke this consent at any time so long as I provide a written and dated revocation of such consent to the Civil Rights Compliance Office at least 5 days prior to revocation.

_____
Employee's Name (Print)

_____
Employee's Signature

_____
Date

Form RA3