LEWIS-CLARK STATE COLLEGE

AUTHORIZATION FOR LIMITED RELEASE OF MEDICAL INFORMATION

I, _____, authorize Lewis-Clark State College's Equal Employment Opportunity/Affirmative Action Director to receive medical information (including pertinent medical records), and to discuss my medical condition with the following care providers: ***(Please provide the full name, address, and telephone number of all applicable providers.)***

1.
2.
3.

I understand that the forgoing records and medical information are limited only to that information which the College needs to know to evaluate my reasonable accommodation request. Accordingly, the College is attempting to obtain the medical information related to the following, as applicable: (1) confirmation that my medical condition is a disability under the Americans with Disabilities Acts as amended; (2) the functional limitations(s) or work related restrictions associated with the stated disability; (3) why the requested reasonable accommodation is needed; (4) clarification of medical information previously submitted to the University; and/or (5) recommendations regarding alternative accommodations.

I understand that the information that is collected and discussed is to be treated with confidentiality. However, directly relevant information may be shared with supervisors/managers, others who need to know how to address work restrictions and/or accommodations, or those responsible for emergency treatment in order to make decisions or provide advice on matters relating to my request for reasonable accommodation.

This Release terminates 90 days after the date of the signature below.

_____ _____

Employee/Applicant Signature Date