AUTHORIZATION FOR RELEASE AND DISCLOSURE OF MEDICAL INFORMATION

ALBUQUERQUE PUBLIC SCHOOLS

I, _____, Date of Birth _____,
Print Employee's Name

Authorize _____
Name of Practitioner/Facility

To release to my employer, Albuquerque Public Schools, medical information pertinent to the reasonable accommodation below.

From my employer, I have requested the following accommodation:

_____

_____

_____

_____

In support of my performance of the following work related task:

_____

_____

_____

_____

The information referred to above is to be used solely for the purpose of evaluating my request for reasonable accommodation. This authorization shall be valid for a period of 180 days after the date of my signature or earlier if revoked by me.

Return this form to: APS, Office of Equal Opportunity Services

In person: 6400 Uptown Blvd. NE, Suite 210 East

By mail: PO Box 25704, Albuquerque, NM 87125

_____ _____

Employee Signature Date