AUTHORIZATION FOR THE RELEASE AND DISCLOSURE OF MEDICAL INFORMATION

ALBUQUERQUE PUBLIC SCHOOLS

Medical information may be required to determine if the individual meets the Americans with Disabilities Act (ADA) definition of an individual with a disability and is entitled to an accommodation.

Employee#: _____

I , _____ Date of Birth: _____

Print Employee's Name

Authorize_____

Name of Practitioner/Facility

To release medical information regarding my functional limitations related to my medical condition which occurred on (date/s)_____ to my employer, **Albuquerque Public Schools RiskMgmt.Department.** This authorization will expire on (DDMMYear)_____.

If I fail to specify an expiration date, this authorization will expire 12 months from the date signed. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it won't have any effect on any actions the medical provider took before it received the revocation.

This information is to be used for the purpose of engaging in an interactive process to determine my ability to perform the essential functions of my job and whether reasonable accommodations may be necessary and/or warranted. I understand that all the information obtained during this process will be maintained and used in accordance with the ADA confidentiality requirement and the Health Insurance Portability Accountability Act of 1996 (HIPPA).

I further understand that I will be required to provide appropriate documentation of my disability/medical condition, the impact of the functional limitations on my ability to perform the essential functions of my job.

Return this form to:	**APS, Risk Management Department**
In person:	**6400 Uptown Blvd. NE, Suite 400 West**
By mail:	**PO Box 25704, Albuquerque, NM 87125**

By signing below, I further authorize and give permission to APS to secure documentation and information from my physician and or appropriate health care professional.

_____ _____

Employee Signature Date