THE COMMONWEALTH OF MASSACHUSETTS

REASONABLE ACCOMMODATIONS FOR EXECUTIVE DEPARTMENT EMPLOYEES

MEDICAL RELEASE FORM

MAURA T. HEALEY
Governor

KIMBERLEY DRISCOLL
Lieutenant Governor

CONFIDENTIAL

Authorization for Release of Information
By Physician or Agency

I Enter Name of Applicant ., hereby authorize the ADA Coordinator for Enter Name of Agency . to speak with the physician who completed or provided the medical certification/documentation accompanying my reasonable accommodation request. This authorization is limited to information about my disability for which I am requesting reasonable accommodations, including the nature, severity, and duration of the impairment, the activities that it limits, and the extent to which it limits my ability to perform the essential functions of my job.

The purpose of the documentation is to enable the Enter Name of Agency . to determine whether I am a qualified individual with a disability for the purpose of providing the reasonable accommodation requested.

I, Enter Name of Applicant . authorize Enter Name of Physician or Agency .

Address

Telephone number

To release medical information to:

Agency's Name and Address

\S\
Signature of Applicant

Date

This authorization to release medical information about me expires in 90 days from this date.