



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 \_\_\_\_\_, hereby authorize the ADA Coordinator for \_\_\_\_\_ 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 \_\_\_\_\_ to determine whether I am a qualified individual with a disability for the purpose of providing the reasonable accommodation requested.

\_\_\_\_\_  
I, \_\_\_\_\_ authorize \_\_\_\_\_

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone number

To release medical information to:

\_\_\_\_\_  
Agency's Name and Address

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

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