## DEPARTMENT OF EDUCATION APPLICANT/EMPLOYEE CONSENT & AUTHORIZATION TO RELEASE MEDICAL INFORMATION FOR REASONABLE ACCOMMODATION

IMPORTANT: This consent and authorization deals w receipt of your protected medical and health care infor confidential records and reports. Please read it careful	rmation, records, and reports, including
I,, w hereby consent and authorize practitioner) to release and send to the Department of Branch the following information:	
Physician's	
Name:Address:	
Phone:	
I understand this information is to help determine the activities, and any need for reasonable accommodation workplace. I have read the above and fully understand satisfied with the reason and purpose for which my perthat the Civil Rights Compliance Branch may have to spursuant to my request to other administrators in the effect to be processed.	on to enable me to perform my job in the d its contents in its entirety and am rmission is given. I further understand share information that is acquired
My consent is valid until such time that I terminate, in I can revoke this consent at any time so long as I prov such consent to the Civil Rights Compliance Branch a	ride a written and dated revocation of
Ēī	mployee's Name (Print)
Ē	mployee's Signature
Da	ate

Form RA3