AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FOR ADA

STATE OF NORTH DAKOTA

SFN 59516 (4-2010)

Employee Name	Agency Name
Health Care Provider	Facility

Regarding the Following Condition(s):

I hereby authorize the above health care provider to disclose to any person authorized by my employer, including legal counsel, to handle medical information for ADA purposes that is necessary to determine whether I have a disability and whether accommodations can be made to perform the essential functions of my job.

I also authorize any person authorized by my employer to handle medication information for ADA purposes to speak to my treating physician or health care provider directly regarding any questions he or she may have with respect to my condition that relates to the performance of the essential functions of my job and any accommodations that may be necessary.

Please disclose information to the following individuals or entities:

Name	Address	City	State	Zip Code

This authorization is valid for one year from the date indicated below or upon receipt of my signed written notice to withdraw my consent. A photocopy is as valid as an original.

Employee Signature	Date