KU MEDICAL CENTER
The University of Kansas

MEDICAL INFORMATION RELEASE FORM

I, _____(Print Name), hereby authorize you to complete the attached *Medical Information Request Form* and disclose to the ADA Coordinator for the University of Kansas Medical Center (KUMC), and other KUMC representatives as necessary, any records and/or information relating **only to the condition(s)** for which I am requesting reasonable accommodations:

_____

(List the condition(s) for which you are requesting reasonable accommodations)

This information will be used for the purpose of evaluating my request for a reasonable accommodation under the Americans with Disabilities Act (ADA).

I understand that I have no obligation to disclose any information from my medical records, and all information disclosed pursuant to this Release shall be treated as confidential. I also understand that I may revoke this consent at any time by notifying you in writing of my decision, unless you have disclosed the information in reliance on my statement of consent.

I have read this form, or have had it read and explained to me, and I understand its contents.

Employee Signature: _____ Date: _____

Name/Address of Healthcare Provider: Phone Number: _____

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