# AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize my health care providers and any others who have treated me to release to Walla Walla Community College Human Resources Director, all medical records and provide any opinions to Walla Walla Community College concerning my ability to perform job-related functions with or without reasonable accommodation. I also authorize disclosure and discussion as necessary to determine appropriate accommodations.

I hereby authorize Walla Walla Community College Human Resources Director and/or her designee to receive medical information that will allow my employer to evaluate whether I have a disability and any limitations that affect my ability to enjoy an equal employment opportunity. I understand that I will be provided a copy of all correspondence and documents sent to my health care provider(s) and received by Walla Walla Community College from them.

The disclosure of my personal information and records is for the specific purpose of providing the Walla Walla Community College with information on the existence and prognosis for any medically based limitations on my ability to perform the essential functions of my position.

My consent for disclosure shall expire 90 days from the date this consent is signed, unless I expressly revoke my consent earlier than that date.

I understand that my records are protected under Federal (42 CFR) and State (Health Care Information Act) Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. My consent for disclosure is subject to my express revocation at any time prior to the above condition, event, or date, except to the extent that any action has been taken by the Walla Walla Community College.

I further acknowledge that the information to be released was fully described for me and that this consent is given of my own free will.

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**(PRINT)** NAME Date

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EMPLOYEE SIGNATURE