COUNTY OF YOLO

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

(DISABLITY REASONABLE ACCOMMODATION)

I, _____, **HEREBYAUTHORIZE**_____
(Name) (Name)

to release to the County of Yolo medical information pertinent to the reasonable accommodation requested in the attached document.

To any licensed physician, other licensed practitioner, hospital, clinic, or other medically related facility: I authorize you to release to the County of Yolo the above- requested information to be used solely for the purpose of evaluating my request for reasonable accommodation. This authorization shall be valid for a period of 180 days after the date of my signature on this form, or earlier if revoked by me in writing to the County of Yolo. I hereby acknowledge that I have been informed of my right to receive a copy of this authorization request. I further acknowledge that I have been informed that if the medical information contained herein is not released, my reasonable accommodation request may be denied.

Employee Signature _____ Date _____