Human Resources
Administration and Finance

Authorization for Release and Disclosure of Medical Information

I, _____, _____,
(print employee name) (date of birth)

authorize _____
(Name of Practitioner/Facility)

to release to my employer, the University of Houston-Clear Lake (UHCL), medical information pertinent to the accommodation request below.

I have requested the following accommodation from my employer:

I have requested these accommodations in support of my performance of the following work-related task(s):

The information referred to above is 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 unless revoked earlier by me.

Return this form to: Office of Human Resources, Fax: 281-283-2158

_____ _____

Employee Signature Date