



CITY OF SACRAMENTO

AUTHORIZATION FOR THE RELEASE
OF MEDICAL INFORMATION

I, _____, **HEREBY AUTHORIZE** _____
(name) (name)

to release to the **City of Sacramento** 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, or United States Veteran Administration: I authorize you to release to the City of Sacramento 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 180 days after the date of my signature or earlier if revoked by me in writing to the City of Sacramento. 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 may be denied.

Employee Signature

Date