ALAMEDA COUNTY

RELEASE OF INFORMATION CONSENT

(Consent for Release of Patient Treatment and Medical Information)

In connection with my request for reasonable accommodation and/or return to work,
I, ___________________________________, hereby authorize Dr. ___________________________________,
or his/her designee, to release to Alameda County any and all health records and information pertaining to my disability and ability to work.

I consent and request that they be permitted to examine and obtain copies of all hospital, medical, treatment and health records of every sort and kind and talk to doctors and other treatment providers regarding all matters relating to examination, diagnosis and treatment of me.

The medical records and information may be released for the following purposes: (1) to address my permanent limitations in order to process my request for reasonable accommodation, (2) to review and evaluate any Description of Employee's Essential Job Functions (EFJA/EF5) for returning to my usual and customary position or alternate job placement, (3) to disclose to any Alameda County third party administrator, with respect to a workers' compensation claim, and (4) to disclose to the Alameda County Employees' Retirement Association with respect to an application for disability retirement.

Please send the requested information to:

Fax:	Phone:

I understand the following:

- This authorization to use or disclosure my individually identifiable health information as described in this document is voluntary.
- This release will remain valid through the completion of the County of Alameda's disability accommodation process, including, but not limited to, the review and determination of disability retirement or until two years from the date of signature unless a different date is specified here ______________.
- I have the right to revoke this authorization by sending my notice stopping this authorization to the person and location identified directly above as the receipt of the requested information. The authorization will stop on the date my request is received except to the extent that the disclosing party or others have acted in reliance on the authorization.
- I am signing this authorization voluntarily and treatment, payment or eligibility for benefits will not be affected if I do not sign this authorization unless I am other
- Wise fully informed, in writing, of any affect on my treatment, payment or eligibility for benefits before I have signed this authorization.
- If the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.
- A copy of this authorization is as valid as the original and I have a right to a copy of this authorization.

Print Name:	**Signature:**	**Date:**