ALAMEDA COUNTY

CONSENT TO RELEASE MEDICAL INFORMATION

In connection with my request for family and medical leave, reasonable accommodation and/or ability to work, I ________________________________, hereby authorize my clinician ________________________________, or his/her designee, to release to Alameda County any relevant medical information pertaining to my medical condition and/or ability to work.

The relevant medical information may be released for the following purposes only: (1) to address my request for family/medical leave, (2) temporary/permanent work limitations in order to process my request for a temporary modified work assignment and/or reasonable accommodation, (3) to review and evaluate any Description of Employee's Essential Job Functions (Form EF5) for returning to my usual or alternate job, (4) to disclose information to Alameda County's Third Party Administrator, with respect to a workers' compensation claim.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Please send the requested information to:

Fax:	Phone:

I understand the following:

- This authorization to use or disclose medical information pertaining to my medical condition and/or ability to work as described above is being signed voluntarily. Treatment, payment or eligibility for benefits will not be affected if I do not sign this authorization unless I am otherwise fully informed, in writing, of any affect on my treatment, payment or eligibility for benefits before I have signed this authorization.
- This release will remain valid through the completion of my disability leave/temporary modified work assignment/the County's reasonable accommodation process or until two years from the date of signature unless a different date is specified here _____________.
- A copy of this authorization is as valid as the original, and I am aware that I have a right to a copy of this authorization.
- I have the right to revoke this authorization at any time by providing written notification to the person and location identified directly above. The revocation will become effective on the date my request is received, except to the extent that the disclosing party or others have acted in reliance on the authorization.

Print Name:	Signature:	Date: