CT Department of Mental Health and Addiction Services (DMHAS)
Equal Employment Opportunity Office

Authorization for Disclosure and Release of Medical Information Form

I, _____ whose home address is
[Name]

_____
[Address]
and whose date of birth is _____**HEREBY AUTHORIZE**

_____
[Provider's Name and Phone Number]
to release medical information pertinent to the reasonable accommodation I requested to the DMHAS Equal Employment Opportunity Office, as well as, persons in DMHAS Human Resources that are working on assisting me with a reasonable accommodation.

ADA Coordinator --DMHAS Equal Employment Opportunity Office
Connecticut Valley Hospital
171 Bow Lane (Cottage 20)
P.O. Box 351
Middletown, CT 06457
Phone: 860-262-6883 Fax: 860-262-5197

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 DMHAS Equal Employment Opportunity Office information to be used solely for the purpose of evaluating my request for reasonable accommodation. Initial _____

ACKNOWLEDGEMENT

I hereby acknowledge that I have been informed of my right to receive a copy of this authorization request.
I acknowledge that I have the right to refuse to sign this Authorization.
I acknowledge that I may revoke this Authorization in writing at any time. I understand that if I revoke this Authorization, the information described above may no longer be used or disclosed for the purpose described in this written Authorization. To revoke this Authorization, please send a written statement to:

ADA Coordinator DMHAS Equal Employment Opportunity Office
Connecticut Valley Hospital
171 Bow Lane (Cottage 20)
P.O. Box 351
Middletown, CT 06457
Phone: 860-262-6883 Fax: 860-262-5197

My signature below indicates that I have read and understand this Authorization and its terms.

_____ _____
Signature Date