CALIFORNIA STATE UNIVERSITY EAST BAY

CALIFORNIA STATE UNIVERISTY, EAST BAY
Risk Management

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please complete and provide to your doctor along with Medical Inquiry Accommodation Form.

This release is only needed to clarify work restrictions and to obtain timelines for the requested accommodation(s). This is not a release for a medical diagnosis or medical information/records.

**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 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's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.*

1. Doctor's Name:_____

   Address:_____

   City:_____ State:_____ Zip Code:_____

   Phone:_____ Fax:_____

2. Doctor's Name:_____

   Address:_____

   City:_____ State:_____ Zip Code:_____

   Phone:_____ Fax:_____

I hereby acknowledge I have been informed of my right to receive a copy of this authorization upon request. I further acknowledge I have been informed if the medical information covered herein is not released, my request for a reasonable accommodation may be denied. I understand this authorization shall become effective immediately upon execution.

I, _____ , authorize my treating physician/health care provider to release information to California State University, East Bay, or its agent, in the form of medical documentation, telephone calls, faxes or emails regarding medical information relating to the current health condition(s) for which I am requesting a reasonable accommodation(s).

Signature: _____ Date:_____

Return this form to: **California State University, East Bay Risk Management, Attn: Jill Millican, 25800 Carlos Bee Blvd Hayward, SA 1604, CA 94542**