DISTRICT SCHOOL BOARD OF PASCO COUNTY
OFFICE FOR EMPLOYEE RELATIONS
AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

MIS Form #204
Rev. 01/18

Date: ______________________________

Name of Person Requesting ADA Accommodations:

First: ______________________________ Last: ______________________________

Employee #: ______________________________ DOB: ______________________________

Location (School/Dept): ____________________ Position: ______________________________

Health Care Provider:

Name: ____

Address: ____

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Phone: ______________________________ Fax: ______________________________

As it relates to a request for an Americans with Disabilities Act (ADA) accommodation(s) only, I authorize my health care provider to submit accurate and complete information regarding my diagnosed medical condition to the Equity Manager, District School Board of Pasco County. My signature also authorizes my health care provider to communicate with the Equity Manager regarding my request for reasonable accommodation(s).

Signature: ____