



**CONFIDENTIAL**

**Americans with Disabilities Act (ADA)  
Request for Reasonable Accommodation**

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

Please complete and return along with your *Request for Reasonable Accommodation Form*.

This release will be submitted to your doctor(s) in the event that additional information is needed regarding the medical condition(s) for which you are requesting reasonable accommodation(s).

1. Name: \_\_\_\_\_ Employee I.D. No. \_\_\_\_\_

2. Home Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

3. Department: \_\_\_\_\_ Job Title: \_\_\_\_\_

Ext: \_\_\_\_\_

4. Physician's Name: \_\_\_\_\_

5 Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

6. Physician's Name: \_\_\_\_\_

7. Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

I hereby authorize California State University, Los Angeles, or its agent, to contact Dr.(s)

\_\_\_\_\_  
\_\_\_\_\_

to request and obtain all medical information related to the current health condition(s) for which I am requesting a reasonable accommodation(s).

Signature: \_\_\_\_\_ Date: \_\_\_\_\_