MEDICAL RELEASE

HHS/Health Resources and Services Administration
Division of Health Careers Diversity and Development

I, _______________________________ authorize a Federal Occupational Health (FOH) designated physician to contact my physician, ________________________, to receive medical records and discuss my medical condition.

I understand that the information discussed is to be confidential. Relevant information may, however, be shared with supervisors/managers concerned with work restrictions and/or accommodations, personnel who may provide first aid and emergency treatment, and government officials investigating compliance with the ADA.

________________________________          ____________________
Name                                  Date

________________________________              ____________________
Witness                               Date

D5H03HE25002