AUTHORIZATION TO RECEIVE OR RELEASE MEDICAL INFORMATION

EXPLANATION:
This authorization to receive or release medical information is being requested of you to comply with the terms of California Code Sections 56 et seg.

AUTHORIZATION:
I hereby authorize _____, _____ to
(name of physician) (address of physician)
furnish to an agent, designee, or representative of the _____ School District
(district name)
the following information regarding _____ for purpose(s) of making an
(employee name)
assignment decision.

Physician: Please describe in your report in what way the condition of the applicant under your care affects his/her work. Has the applicant been under prolonged and continuing treatment? What treatment is being received at this time? Will this condition prevent the applicant from performing his/her regularly assigned duties, or will it completely prevent him/her from reporting to the site to which he/she is assigned?

DURATION:
This authorization shall become effective immediately and shall remain in effect as long as necessary for the _____School District to accomplish the above stated purpose.

ADDITIONAL COPY:
I further understand that I have the right to receive a copy of this authorization upon my request.
Copy requested and received: Yes _____ No _____ Initial: _____

SIGNATURES:

Signed: _____
(Employee)

Witness: _____

Date: _____