

**GADSDEN STATE COMMUNITY COLLEGE  
MEDICAL/HEALTHCARE INFORMATION RELEASE FORM**

TO: \_\_\_\_\_

Pursuant to my request for reasonable accommodation under the Americans with Disabilities Act, the ADA Coordinator and/or the Human Resources Director for Gadsden State Community College is authorized to determine whether I have a physical or mental impairment which limits a major life activity, to determine what restrictions I have that impact the duties of my position, and to evaluate the effectiveness of possible reasonable accommodations.

I hereby authorize and direct you, your office/practice, its Custodian of Records and/or persons in your employ to release and discuss medical information relating to my request for reasonable accommodation relating to the following condition(s) or diagnosis(es):

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

I do hereby release and hold harmless you, your organization or company, your officers, agents, employees, or independent contractors from any liability or damages, and I do hereby waive all claims or causes of action against you, your organization or company, your officers, agents, employees or independent contractors, which may result from furnishing the requested information.

I understand that I can revoke this release in writing at any time by sending a written revocation of authorization to:

ADA Coordinator, Gadsden State Community College, P. O. Box 227, Gadsden, AL 35902-0227

Name (print): \_\_\_\_\_

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

Birthdate: \_\_\_\_\_ Last 4 Digits of Social Security No.: \_\_\_\_\_