CSUF | DIVISION OF Human Resources and Inclusive Excellence

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

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

This release is only needed to clarify work restrictions and to obtain timelines for the requested accommodation(s). It is not a release for medical information.

1. Doctor's Name:_____

   Address:_____

   City:_____ State:_____ Zip Code:_____

   Phone:_____ Fax:_____

2. Doctor's Name:_____

   Address:_____

   City:_____ State:_____ Zip Code:_____

   Phone:_____ Fax:_____

I hereby acknowledge I have been informed of my right to receive a copy of this authorization upon request. I further acknowledge I have been informed if the medical information covered herein is not released, my request for a reasonable accommodation may be denied. I understand this authorization shall become effective immediately upon execution.

I, _____, authorize my treating physician/health care provider to release information to California State University, Fullerton, or its agent, in the form of medical documentation, telephone calls, faxes or emails regarding medical information relating to the current health condition(s) for which I am requesting a reasonable accommodation(s).

Signature: _____ Date:_____

Return this form to: **California State University, Fullerton/Dvision of Human Resources, Diversity and Inclusion**
Total Wellness, P.O. Box 6806, Fullerton, CA 92834-6806