City & Borough of Juneau
Americans with Disabilities Act Accommodation Request
Employee Authorization for the Release of Medical Information

I authorize _____ (health care provider name) to release to my employer, the City & Borough of Juneau, medical information relevant to my request for accommodation under the Americans with Disabilities Act (ADA). The information will be used to determine my eligibility for workplace accommodations under the ADA and, if eligible, what reasonable accommodation(s) can be made.

I also authorize my treating physician or health care provider to speak with my employer regarding any questions that specifically relate to my medical condition(s), the performance of my job, and any workplace accommodations.

This authorization will remain valid for 180 days after the date of my signature or earlier if revoked in writing to the City & Borough of Juneau. A facsimile, scan, or photocopy is valid as the original.

I acknowledge that I have been informed of my right to receive a copy of this authorization request. I further, acknowledge that I have been informed that if the medical information is not released, my accommodation(s) may be denied.

Employee Name: _____ Work phone _____

Employee Signature and date

Notice to Medical Provider: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member, except as specifically allowed by this law. To comply with this law, the City & Borough of Juneau, as an employer, asks that you not provide any genetic information when responding to this request for medical information. "Genetic information, "as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Attachment(s)

- ☐ ADA Health Care Provider Documentation form
- ☐ Position Description for _____
- ☐ Other _____