AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____ (employee name), hereby authorize _____ (treating healthcare provider's name) to release information requested on the attached *Request for Healthcare Provider Response* form. This information will be provided to the indicated Santa Clara University Human Resources representative for the purpose of determining my requests for a reasonable accommodation and/or for medical leave under applicable laws and University policies.

I, _____ (employee name), understand that I have a right to receive a copy of this authorization for the release of medical information.

_____ _____

Signature of Patient (Santa Clara University employee) Date

_____

Printed name of Patient