AUTHORIZATION TO RELEASE MEDICAL REPORT/S

EXPLANATION
This authorization to release medical information is being requested of you is to comply with the terms of the Confidentiality of Medical Information Act of 1981, Section 56, et seq., of the California Civil Code and the HIPAA Privacy Rule.

Dr. Debra Dupree and Barbara Tourtellott of Relationships at Work, Inc. are medical professional independent disability management consultants who will be facilitating your Interactive Process Accommodation meeting. Your employer will not receive the medical report/s requested below. We maintain strict confidentiality of medical information, which we utilize only to provide thorough assistance with the reasonable accommodation process.

A. AUTHORIZATION
I hereby authorize: Athens Administrators PO Box 4029, Concord, California to furnish to:
Dr. Debra Dupree, Relationships at Work, Inc., 755 F Avenue, Coronado, CA 92118, Fax 619-923-3611 or dr.dupree@relationships-at-work.com.
Consultants Dr. Debra Dupree, Certified Professional Disability Manager / Certified Ergonomist and/or Barbara Tourtellott, Registered Occupational Therapist and Certified Ergonomist medical reports pertaining to work injury or illness of :

Name of Injured Worker _____ Employer _____
Claim # _____ Date of injury _____

B. **I UNDERSTAND** that I have the right to limit the type of information to be released. I have indicated below the information which is authorized for release:

ANY OF THE FOLLOWING INFORMATION: Medical provider Permanent and Stationary Report/s, return to work notes; Medical Specialist/s or QME/AME reports; Functional Capacity and Job Analyses; Activities of Daily Living OR
_____

C. USES
This information supplied is to be used for the following purposes(s):
To more fully assist in determining reasonable accommodation for essential job duties

D. DURATION
This authorization shall become effective immediately and shall remain in effect until: __one year past date below_____ .

E. RESTRICTIONS
I understand that the recipient may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

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

G. SIGNATURE

Signed: _____ Date: _____
Printed Name: _____

H. Comments: