

81/9 2IILFH RI %HQHILWV DQG +5 2SHUDWLRQV
\$\$\$FFRPPRGD\$SRQFDQW
+HDOWK3&URHLGHU 0HIGLILFDOWLRQ)RUP

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HUMAN RESOURCES

Americans with Disabilities Act Medical/Healthcare Information Release Form

This form will not be placed in your employment record. Please submit a Medical/Healthcare Information Release Form for each healthcare provider you authorize to release information.

Patient Name: _____

Date of Birth: _____

Medical ID/Patient Number or Last 4 digits of Social Security: _____

Name and Title of Healthcare Provider: _____

Name o:03.889 (o)O. _____ ()14 45 _____ 5act <<>>BDC 0 Tw ()Tj 19.628 MC /Form <</MCID 9 (6