RELEASE OF HEALTH INFORMATION AUTHORIZATION

I, , knowingly, intelligently, and voluntarily authorize the disclosure of my personal health information to the City of Salem from the following health care provider(s):

Please list provider name(s), addresses, and phone numbers

The purpose of this disclosure will be for the City of Salem to:

☐ **Certify FMLA/OFLA Leave**

☐ **Assess an accommodation requested under the Americans with Disabilities Act (ADA)**

I understand that the City will maintain the confidentiality of all medical information collected during this process, regardless of where the information comes from. I understand that if I fail to authorize disclosure, that the City will make its determination about my ADA accommodation request based upon available information.

☐ Release all information relating to:

Authorization

I, , have had a full and fair opportunity to read and consider the contents of this authorization. I understand that by signing this form, I am confirming my authorization that the provider(s) named above may use and/or disclose to the City my personal health information. Unless revoked, this authorization expires on

Signature: _____ Date:

Printed Name: _____