DEPARTMENT OF CORRECTIONS

Medical Confidential File
Standard Release

EMPLOYEE'S PRINTED NAME: _____

LAST 4 DIGITS OF SOCIAL SECURITY NUMBER: _____

I understand the Americans with Disabilities Act (ADA) provides that medical-related information shall be kept confidential except the following may be provided without my consent:

1. Supervisors and managers may be informed about necessary restrictions on my work or duties and necessary accommodations;

2. First aid and safety personnel may be informed, when appropriate, if I have a disability that might require emergency treatment or if any specific procedures are needed in the case of fire or other evacuations;

3. Government officials investigating compliance with the ADA and other federal and state laws prohibiting discrimination on the basis of a disability or handicap may be provided relevant information upon request; and

4. Relevant information may be provided to state and federal agencies and persons having the legal authority to obtain such information.

No other disclosure of medical information from my file will be made without my written consent.

_____ _____

EMPLOYEE'S SIGNATURE DATE

NOTE: In the event you refuse to sign this form, you must note "refused to sign" and the date of your refusal on the applicable signature line and return the form to your personnel office immediately.

FORM TO BE FILED IN EMPLOYEE'S MEDICAL CONFIDENTIAL FILE