



MEDICAL RELEASE

**HHS/Health Resources and Services Administration
Division of Health Careers Diversity and Development**

I, _____ authorize a Federal Occupational Health (FOH) designated physician to contact my physician, _____, to receive medical records and discuss my medical condition.

I understand that the information discussed is to be confidential. Relevant information may, however, be shared with supervisors/managers concerned with work restrictions and/or accommodations, personnel who may provide first aid and emergency treatment, and government officials investigating compliance with the ADA.

Name

Date

Witness

Date