EMPLOYEE MEDICAL RELEASE FORM

Sacramento City Unified School District – RSK – F204B

Sacramento City Unified School District

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize my attending physician to release to my employer, Sacramento City Unified School District ("District"), the medical and psychological information described below.

This authorization is limited to the following types of information: information regarding my physical or psychological condition and my ability to safely perform my job task(s), including medical history, findings, x-rays, EKGs, laboratory studies, diagnosis, psychological or psychiatric evaluations, testing results and reports, treatment and recommendations.

This authorization is limited to the following uses of the information released: the purpose of the information is to assist the District in its determination of whether I am able to perform safely all the essential functions of the job, whether I would require accommodation, and if so, what types of accommodation are reasonable, determine my medical or psychological status and history in order to comply with any applicable requirements relating to accommodating disabilities and or providing a safe work environment.

I consent to and authorize the District to arrange for any additional examination of my condition by a different health practitioner, at District expense; such examination shall be job related and consistent with the purposes set forth in this release. I release the District from any claims, damages or liabilities of any kind which may arise from the medical examination.

I also authorize my employer, Sacramento City Unified School District, to release to the examining physician or psychologist, any and all information, including confidential personnel or medical information, which would be relevant to my physical or psychological condition and my ability to safely perform my job task.

This authorization shall remain valid until six months after the date I have executed this release of medical information.

_____ _____

Employee Name (Printed) **Date**

_____

Employee Signature

ATTENDING PHYSICIAN:

Name: _____ Phone:_____

Address: _____

City: _____ State: _____