SONOMA STATE UNIVERSITY | Office of Human Resources

Authorization to Release Medical Records

_____ I Decline to provide the following release.

_____ I agree to provide the following release.

To whom it may concern:

I, ______________________________ (name), hereby authorize Sonoma State University to receive records or reports of examination done by ____ (licensed Medical Doctor) regarding my fitness to work, any potential work restrictions I may have or reasonable accommodations I may need, and other such medical information as may be pertinent to my job performance based on my current condition. The records will be sent to the ADA Coordinator in the Payroll & Benefits Department at Sonoma State University, 1801 E. Cotati Avenue, Rohnert Park, CA 94928.

This authorization is effective __________(date) and will remain effective through ___________(date) unless otherwise rescinded.

I understand that I will receive a copy of this authorization upon request.

____

Employee Name

____

Date