WAIVER AND AUTHORIZATION TO RELEASE INFORMATION

1. I, _____, hereby authorize Pierce College Human Resources to receive medical information that will allow my employer to evaluate whether I have a disability and any limitations that affect my ability to enjoy an equal employment opportunity. I understand that I will be provided a copy of all correspondence and documents sent to my health care provider(s) and received by Pierce College from them.

2. The disclosure of my personal information and records is for the specific purpose of providing Pierce College with information on the existence and prognosis for any medically based limitations on my ability to perform the essential functions of my [Position] with the [Department].

3. My consent for disclosure shall expire 90 days from the date this consent is signed, unless I expressly revoke my consent earlier than that date.

4. I understand that my records are protected under Federal (42 CFR) and State (Health Care Information Act) Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

5. I further acknowledge that the nature of the information to be released was fully described for me and that this consent is given of my own free will.

_____ _____

EMPLOYEE Date