Applicant Authorization for the Release of Medical Information

I, _____ **hereby authorize** _____
(applicant name) (physician name)
to release to Butler County Community College medical information pertinent to the reasonable accommodation requested in the attached document.

To any licensed physician, other licensed practitioner, hospital, clinic, or other medically related facility, or United States Veteran's Administration: I authorize you to release to Butler County Community College the above requested information to be used solely for the purpose of evaluating my request for reasonable accommodation. This authorization shall be valid for a period of 180 days after the date of my signature or earlier if revoked by me in writing to Butler County Community College. I hereby acknowledge that I have been informed of my right to receive a copy of this authorization request. I further acknowledge that I have been informed that if the medical information contained herein is not released, my reasonable accommodation may be denied.

_____ _____
Applicant Signature Date