DAVIS BEHAVIORAL HEALTH
Community • Commitment • Change

Health Care Provider – Medical Information Release Form

Today's Date:

I,_________________________, voluntarily give the Davis Behavioral Health Human Resources Department permission to contact my physician(s) and/or healthcare provider(s) as listed below to obtain information related to my disability; any related limitations, and recommendations on necessary accommodations in conjunction with a Fitness for Duty Evaluation. Please submit additional copies of this form if additional space is required to include all physicians and/or health care providers.

Name of Physician/Health Care Provider:	____________________
Name of Hospital/Practice:	____________________
Hospital/Practice Address:	____________________
Hospital/Practice Phone Number	____________________
Name of Physician/Health Care Provider:	____________________
Name of Hospital/Practice:	____________________
Hospital/Practice Address:	____________________
Hospital/Practice Phone Number	____________________
Name of Physician/Health Care Provider:	____________________
Name of Hospital/Practice:	____________________
Hospital/Practice Address:	____________________
Hospital/Practice Phone Number	____________________

I have been given the opportunity to ask questions about this form and to have them answered to my satisfaction. I further understand that relevant information obtained may be shared with the supervisor(s) in my immediate work department and other DBH administrative staff who may be involved in assisting in the Fitness for Duty Evaluation process and the development of any related reasonable accommodations to assist me in completing my assigned essential work-related responsibilities.

Name:	____________________	Signature:	____________________
Today's Date:	____________________	Date of Birth:	____________________