



**Health Information Release Waiver  
For ADA/AA Accommodations**

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\_\_\_\_\_  
**Name (please print)**

\_\_\_\_\_  
**Address**

\_\_\_\_\_  
**City**

\_\_\_\_\_  
**State**

\_\_\_\_\_  
**Zip Code**

\_\_\_\_\_  
**Home Phone Number**

\_\_\_\_\_  
**Work Phone Number**

I, \_\_\_\_\_, am requesting reasonable accommodations for my medical condition(s) through my employer, Georgia College. I give a representative of the Office of Human Resources and Employee Relations permission to speak with and/or request written information regarding medical assessment(s) on my behalf. I authorize my health care provider to release relevant information regarding my medical condition. I realize that this information will be kept in confidence and will be used only for purposes of approval of reasonable accommodations under the Americans with Disabilities Act Amendments Act (ADAAA).

\_\_\_\_\_  
**Employee Signature**

\_\_\_\_\_  
**Date**