Lake Superior College
A member of Minnesota State

Authorization for Release of Medical Information for Americans with Disabilities Act ("ADA") Reasonable Accommodations

Date: _____

Health Care Provider Name: _____

Health Care Provider Address: _____

Patient Name: _____ Patient Date of Birth: _____

Patient Address: _____

This form does not cover, and the information to be disclosed should not contain, genetic information. "Genetic Information" includes: information about an individual's genetic tests; information about genetic tests of an individual's family members; information about the manifestation of a disease or disorder in an individual's family members (family medical history); an individual's request for, or receipt of, genetic services, or the participation in clinical research that includes genetic services by the individual or a family member of the individual; and genetic information of a fetus carried by an individual or by a pregnant woman who is a family member of the individual and the genetic information of any embryo legally held by the individual or family member using an assisted reproductive technology.

I, _____ [Patient Name], authorize _____ [Name of Healthcare Provider] to disclose to Jestina Vichorek at Lake Superior College or any authorized Human Resources staff at Lake Superior College to receive medical information that is specifically related and necessary to determine whether I have a disability and whether accommodations can be made. I authorize Jestina Vichorek at Lake Superior College or any authorized Human Resources staff at Lake Superior College, to speak to my treating health care provider directly with respect to my condition as it relates to the performance of the essential functions of my job and any accommodations that may be necessary, to the extent that it will assist Lake Superior College to make a decision related to my request for accommodation(s) in a timely manner. The persons allowed by this Authorization are only

authorized to request information from my treating health care provider that is job-related and does not include genetic information.

I understand that the requested information is for the above-mentioned purposes only. I understand that I may refuse to sign this Authorization. However, I understand that if I refuse to sign this Authorization, I am responsible to ensure Lake Superior College receives the requested medical information. I also understand that this information shall remain confidential, available only under limited conditions specified under law.

This Authorization is valid for one year from the date indicated below or upon receipt of my signed written notice to withdraw my consent. A photocopy is as valid as an original.

Patient Signature: _____ Date: _____

All documentation may be sent to:

Lake Superior College
Attn: Human Resources
2101 Trinity Road
Duluth, MN 55811
Fax: 218-733-5937

OR:

Jestina Vichorek, Assoc. Vice President of Human Resources
Lake Superior College
2101 Trinity Road
Duluth, MN 55811
Fax: 218-733-5937
Phone: 218-733-7677
Jestina.vichorek@lsc.edu