OMB Number:
Respondent Burden: 15 minutes

Department of Veterans Affairs

AUTHORIZATION FOR LIMITED RELEASE OF MEDICAL INFORMATION

The Paperwork Reduction Act (PRA) of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the PRA. We cannot sponsor or require you to respond to a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 15 minutes including the time it would take to read the instructions, gather necessary facts and fill out the form.

PRIVACY ACT: The information requested on this form is solicited under the authority of Executive Order 13164 that requires the collection of data that will allow measurement and evaluation of the efficiency and appropriateness of the actions taken by the Department of Veterans Affairs in processing accommodation requests. Information from the data collection will become part of a Systems of Records that complies with the Privacy Act of 1974. This system of records is identified as "Reasonable Accommodation Processing Records" as set forth in the Compilation of Privacy Act Issuances via online GPO access at http://www.gpoaccess.gov/privacyact/index.html.

In order to process your accommodation request, since you do not have a visible disability and VA does not have documentation on file, I am requesting medical documentation. Please allow me to request information from your physician, vocational counselor, physical therapist, or other individual with recognized health care credentials and expertise in your condition. Completion of this form is voluntary, but VA may be unable to process your accommodation request without a completed form. Failure to complete this form will have no effect on any other benefits to which you may be entitled. This information is collected under the authority of Title 29 CFR § 1614.203.

I authorize [Enter the name of the Local Reasonable Accommodation Coordinator (LRAC) designated to receive information about reasonable accommodation]
to receive my medical records and discuss the functional limitations caused by my disability and how it relates to my ability to apply for a position or to perform the essential functions of the position I occupy or am applying or to enjoy the benefits and privileges of employment. This authorization applies to the following health care providers.

(Please provide the full name, address and telephone number of the appropriate health care provider(s))

1. NAME	ADDRESS	TELEPHONE NUMBER *(Include area code)*
2. NAME	ADDRESS	TELEPHONE NUMBER *(Include area code)*
3. NAME	ADDRESS	TELEPHONE NUMBER *(Include area code)*

The medical information requested will be limited to information that the DMO/LRAC needs to process my reasonable accommodation request.

I understand this is VA's attempt to obtain the following *(as indicated)*:

- ☐ Confirmation that my medical condition is a disability under the Rehabilitation Act, as amended;
- ☐ The functional limitation(s) or work related restrictions associated with the stated disability;
- ☐ Why the requested reasonable accommodation is needed;
- ☐ Clarification of medical information previously submitted to VA; and/or
- ☐ Recommendations regarding alternative accommodations.

VA will only request medical information that is directly related to the aforementioned.

I understand that the information that is collected and discussed is to be treated with confidentiality. However, directly relevant information may be shared with supervisors/managers; others who need to know to address work restrictions and/or accommodations; or with those responsible for emergency treatment; and/or employees in the Department of Defense's Computer-Electronic Accommodations Program (CAP) in order to make decisions, or provide advice on matters relating to my request for reasonable accommodation.

This release terminates 90 days after the date of the signature below.

EMPLOYEE/APPLICANT *(Please **Print** Name)*

SIGNATURE OF EMPLOYEE/APPLICANT DATE

SIGNATURE OF WITNESS DATE

A Photo copy or facsimile of this form will serve as an original.

This form should be retained separately from the employee's Official Personnel Folder.