

To Whom It May Concern:

I, _____, hereby authorize any hospital, medical practitioner, clinic, other medical or medically related facility, pharmacy, insurance company or government agency to disclose or furnish to Grand Rapids Community College, or its representatives, any and all information with respect to any illness, including mental illness, drug/alcohol abuse, injury, medical history, consultations, prescriptions, treatment or benefits, and copies of all applicable records that may be requested.

This information provided to Grand Rapids Community College or its representatives is to be used solely for the evaluation of a reasonable accommodation for the undersigned, or otherwise qualified individual with a disability who, with or without reasonable accommodation can perform the essential functions of his/her requirements. A Photostatted copy of this authorization is to be considered as valid as the original and is effective for the duration of the evaluation of the reasonable accommodation. This authorization will be considered valid for one year from signature date.

Signature of Authorization

Date

Place where authorization was signed

Witness

Date