

**AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION**

*Completion of this form authorizes the disclosure and/or use of medical information about you. Please provide all requested information, as failure to do so may invalidate this Authorization.*

**Name:** \_\_\_\_\_  
*Please Print*

I hereby authorize \_\_\_\_\_  
to release the following information to the Director of Personnel Services:

- A conclusion regarding the determination of my fitness for duty;
- A description of the nature and extent of any functional limitations on my ability to perform my job, including physical and/or mental limitations;
  - A description of the expected duration of each such functional limitation; and
  - A conclusion as to whether the functional limitation is the result of an industrial injury.

On the University Park campus, mail to Director of Personnel Services, University of Southern California, University Park, Los Angeles, California 90089-0704; on the Health Sciences Campus, mail to Director of Personnel Services, University of Southern California, Health Sciences Campus, Keith Administration Building, Room 409, Los Angeles, California 90089-9030.

This Authorization shall expire after one year.

**Purpose of Disclosure**

The purpose of this Authorization is to allow the University of Southern California access to the information necessary to determine my ability to perform the essential functions of my job, as well as any reasonable accommodations that may be appropriate. However, I understand that if I initiate a lawsuit, arbitration, grievance, or other claim, including a workers' compensation claim, to which the University and I are parties and where I have placed at issue my medical history, mental or physical condition, or treatment, relevant information may be used and disclosed by the University in connection with such proceedings.

**My Rights**

I may refuse to sign this Authorization. My refusal will not affect my ability to receive a fitness-for-duty evaluation, or the results thereof, or the University's obligation to pay. However, I understand that, even if I choose not to sign this Authorization, the University of Southern California may nevertheless obtain a description of the functional limitations that limit my ability to perform the essential functions of my job.

The University will not receive any compensation for the use or disclosure of my medical information.

I may revoke this Authorization at any time, but I must do so in a writing submitted to the above-named health care professional. My revocation will take effect upon receipt, except to the extent that others already have acted in reliance upon this Authorization.

I have a right to a copy of this Authorization. I also have the right to inspect or obtain a copy of the above-described medical information.

**Signature**

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Signature: \_\_\_\_\_