EMPLOYEE CONSENT AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION FOR AMERICANS WITH DISABILITIES ACT (ADA) AND ADA AMENDMENTS ACT (ADAA) REASONABLE ACCOMMODATION

IMPORTANT: This consent and authorization deals with the release, sharing, disclosure, and receipt of your protected medical and health care information, records, and reports, *including confidential records and reports*. Please read it carefully.

I, _____(PRINT NAME)_____, whose date of birth is _____(DOB)_____, hereby authorize _(HEALTH CARE PROVIDER'S NAME)_, to disclose medical and health information, records, reports, whether verbal, written or electronic format which he/she may have or may receive about me to the Judiciary of Guam.

I understand that I may revoke this Consent at any time by providing written notification to the Judiciary of Guam, Attention: HR Office, except to the extent that the program that is to make the disclosure has already taken action in reliance on it.

It is further understood that this Consent constitutes an express waiver of any rule against disclosure otherwise provided by any confidentiality provision of Federal, Local, or other applicable law. This Consent cannot be used for redisclosure to any party not herein specified.

I hereby release _(HEALTH CARE PROVIDER'S NAME)_, and the Judiciary of Guam, their employees, their agents, and representative of agents from all liability and all claims of any nature whatsoever pertaining to disclosure of information, or of any professional opinions, findings, or recommendations as contained in the information, records, and reports to which this release applies. I understand that this Consent and the release provided for herein is binding on my heirs, representatives, agents, or anyone else authorized to act on my behalf.

I am aware the records and reports to which this release applies may contain references to psychological and psychiatric treatment, care and/or counseling.

I understand this information is to help determine the extent of my disability, its effect on work activities, and any need for reasonable accommodation to enable me to perform my job in the workplace. I have read the above and fully understand its contents in entirety.

EMPLOYEE'S NAME (PRINT): _____

EMPLOYEE'S SIGNATURE: _____ **DATE:** _____