CITY COLLEGES OF CHICAGO

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
ACCOMMODATION(S) REQUEST FORM

Please complete and return along with your Reasonable Accommodation Request Form. This release will be submitted to your doctor(s) in the event that additional information is needed regarding the medical condition(s) for which you are requesting reasonable accommodation(s).

TO BE COMPLETED BY EMPLOYEE

Employee Status: ☐ Full-Time ☐ Part-Time

EMPLOYEE INFORMATION

Name: _____ Employee ID: _____

Address: _____ Home Telephone No.:_____
(Street)

_____
(City) (State) (Zip Code)

MEDICAL PROVIDER INFORMATION

Physician's Name: _____

Address: _____ Telephone No.:_____
(Street)

_____ Fax No.:_____
(City) (State) (Zip Code)

Physician's Name: _____

Address: _____ Telephone No.:_____
(Street)

_____ Fax No.:_____
(City) (State) (Zip Code)

I, hereby authorize City Colleges of Chicago, or its agents, to contact the physician(s) listed above to request and obtain all medical information related to the current health condition(s) for which I am requesting a reasonable accommodation(s). I understand that communication with the physician(s) named above will not include personal disclosures that do not pertain to my disability and/or pregnancy.

_____ _____
Signature of Employee **Date**

Return to:
City Colleges of Chicago
EEO, Labor & Employee Relations
180 N. Wabash
Chicago, Illinois 60601
Fax: (312) 553-3353
eeofficer@ccc.edu