**COLORADO DEPARTMENT OF TRANSPORTATION**

# AUTHORIZATION TO RELEASE OR OBTAIN INFORMATION

**Section 1** Completed by employee

I authorize any individual, physician, health care provider, medical practitioner, nurse, pharmacist, hospital, clinic or other medical or medically related facility who has any information as to diagnosis, treatment or prognosis of any physical or mental condition of me, and any information pertaining to the effects of my medical condition on my ability to perform my occupation, to provide any and all such information to_____, Americans With Disabilities Act (ADA) Representative for the Colorado Department of Transportation (CDOT), or his/her designated representative at CDOT.

**I understand that the information provided to, or obtained by _____, will be used exclusively by CDOT to determine whether I am a qualified person with a disability under the Americans With Disability Act, and to carry out the requirements of the ADA. Any information released to, or obtained by_____, may not be provided by him/her to anyone who does not have a responsibility in carrying out the requirements of the ADA as those requirements pertain to me.**

_____ _____

(Signature) (Date)