

HOUSING AUTHORITY OF AUGUSTA, GEORGIA  
AUTHORIZATION FOR RELEASE OF INFORMATION  
REGARDING REASONABLE ACCOMMODATION(S) REQUEST

RE: Household member with disability:

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I hereby authorize \_\_\_\_\_  
[Insert name of health care provider or other appropriate documenting authority] to consult with representatives of the Augusta Housing Authority, in writing, in person, or by telephone concerning the physical or mental impairment(s) that I assert to qualify as an individual with a disability for the sole purpose of this reasonable accommodation request. I hereby authorize the release of information to the Augusta Housing Authority regarding the request for reasonable accommodation described on this form. This release shall constitute a limited authorization for the release of information, as described below.

This Authorization solely authorizes the release of information necessary to verify the following:

1. Documentation necessary to verify that the above-named individual meets the definition of a "qualified individual with a disability", as defined below;
2. A description of the needed reasonable accommodation(s); and,
3. A description of the identifiable relationship between the individual's disability and the requested reasonable accommodation(s).

For purposes of this Release, a "Qualified Individual With a Disability" is defined as a person who has a physical or mental impairment that:

1. Substantially limits one or more major life activities
2. Has a record of such an impairment
3. Is regarded as having an impairment

"A Physical or Mental Impairment" is defined as:

1. Any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: Neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive; digestive; genito-urinary; hemic and lymphatic; skin; and endocrine; or
2. Any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities. The term "physical or mental impairment" includes, but is not limited to, such diseases and conditions as orthopedic, visual, speech, and hearing impairments, cerebral palsy, autism, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional illness, drug addiction and alcoholism. "Major life activities" means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing and learning.

"Major Life Activities" include functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

"Has a Record of Such an Impairment (mental or physical)" means has a history of, or has been misclassified as having, a mental or physical impairment that substantially limits one or more major life activities.

"Is Regarded As Having an Impairment" means:

1. Has a physical or mental impairment that does not substantially limit one or more major life activities but is treated by a recipient as constituting such a limitation.
2. Has a physical or mental impairment that substantially limits one or more major life activities only as a result of the attitudes of others toward the impairment.
3. Has none of the impairments defined by Section 504's definition of "physical or mental impairment" but is treated by a recipient as having such an impairment.

In addition, I authorize \_\_\_\_\_  
[Insert name of health care provider or other appropriate documenting authority] to provide only documentation that is necessary to verify that I meet the definition of a "Qualified Individual with a Disability", as defined above. This Authorization For Release of Information should only seek information that is necessary to determine if the requested reasonable accommodation is needed because of a disability.

This Authorization does not authorize the Augusta Housing Authority to examine my medical records, including diagnosis or test result(s); nor does this authorize the release of detailed information about the nature or severity of my disability. Any information or documentation released as a result of this Authorization shall be kept confidential and will not be shared with anyone unless required to make or assess a decision to grant or deny a reasonable accommodation request.

\_\_\_\_\_  
Name of Family Member/Parent/Legal Guardian [Print]

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship to Resident

\_\_\_\_\_  
Date

PLEASE PROVIDE THE FOLLOWING INFORMATION:

(1) Name of Health Care Provider/Documenting Authority:

\_\_\_\_\_

(2) Address of Health Care Provider/Documenting Authority:

\_\_\_\_\_

(3) Telephone Number of Health Care Provider/Documenting Authority:

\_\_\_\_\_

(4) Facsimile Number of Health Care Provider/Documenting Authority:

\_\_\_\_\_