## MEDICAL INFORMATION RELEASE

DATE _____

TO _____
HEALTH CARE PROVIDER'S NAME

_____
HEALTH CARE PROVIDER'S ADDRESS

_____

FROM _____
COMMUNITY ASSOCIATION NAME

_____
COMMUNITY ASSOCIATION ADDRESS

_____

RE: **REQUEST FOR ACCOMMODATION**

MEMBER'S NAME _____

ADDRESS _____

The member named above has requested that our community association accommodate his/her disability by (state nature of accommodation request): _____

_____

TO THE MEMBER:

**RELEASE**: I hereby authorize the release of the requested information. Information obtained under this consent is limited to information that is up to 5 years old. The community association named above is to verify information that is up to five years old, which has been authorized by me

SIGNATURE _____ DATE _____