LOS RIOS COMMUNITY COLLEGE DISTRICT
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
Los Rios Faculty

I, ____________________________________, authorize the release of the
(Print employee's name)

medical information described below to the Los Rios Community College District Extended Paid Catastrophic Sick Leave Committee for the purpose of determining my eligibility for Extended Paid Catastrophic Sick Leave. This authorization applies to the following type of information:

> All medical information about me provided in response to the Physician's Statement accompanying this Authorization for Release of Medical Information describing the incapacitating nature and probable duration of my medical condition.

This authorization to release information is valid until I either return to my customary duties as an employee of the Los Rios Community College District or my employment as a Los Rios Community College District employee ends. However, regardless of whether I have returned to work or my employment has ended, this Authorization for Release of Medical Information shall expire one year from the date of this authorization.

_______(Employee's Initials) I understand that I have the right to receive a true copy of this authorization. By placing my initials to the left of this clause on the original authorization, I hereby acknowledge that a true copy of this authorization has been received. A copy of this authorization shall be as valid as the original.

Dated: ________________________ ________________________________
(Employee's Signature)