



PUBLIC HOUSING and COMMUNITY DEVELOPMENT AUTHORIZATION FOR RELEASE OF INFORMATION

RE: Household member with disability: _____

I hereby authorize the release of information to Public Housing and Community Development (PHCD) 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.

I hereby authorize _____ to consult with representatives of the Public Housing and Community Development (PHCD), 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.

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 body systems including, but not limited to: neurological, musculoskeletal, special sense organs, respiratory, and speech organs; **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 visual, speech and hearing impairments, epilepsy, multiple sclerosis, cancer, etc.

"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 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 impairment.

In addition, I authorize _____ 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 solely authorizes the release of information necessary to verify the following:

1. Documentation necessary to verify that the person meets the definitions noted above;
2. A description of the needed accommodation; and,
3. A description of the identifiable relationship between my disability and the requested accommodation(s).

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 Miami-Dade Public Housing Agency 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.

The information/documentation released as a result of this Authorization shall be kept confidential and not 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

Date

Relationship to Resident

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:



This material is available in an accessible format upon request. Please call the Section 504/ADA Coordinator at 786-469-2155 or Florida Relay Service TDD/TTY 800-955-8771.

ASC/02/5110