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Consent To Disclose Medical Information for Workplace/Education Institutions Accommodation Applications

Patient Name: ____

Date of Birth: ____

I, the undersigned, authorise Wesmed Medical to disclose relevant medical information regarding my diagnosis and treatment of Attention Deficit Hyperactivity Disorder (ADHD) to my workplace or educational institution. This disclosure is for the purpose of requesting reasonable accommodations to support my medical condition.

Details of the Information to be Disclosed:

- Diagnosis of ADHD

- Recommended accommodations that may support my condition in the workplace or educational setting

Purpose of the Disclosure:

The purpose of this disclosure is to obtain necessary accommodations at my workplace or educational institution to better manage my condition and enhance my work or academic performance.

Name of Workplace/Educational Institution: ____

Contact Information of Workplace/Educational Institution:

Address: ____________________________

Phone: ______________________________

Email: ______________________________

Duration of Consent:

This consent is valid for a period of one year from the date of signing unless otherwise revoked in writing. I understand that I may revoke this consent at any time, except to the extent that action has already been taken in reliance upon it.

Signature of Patient: ____________________________

Date: ________________