U.S. TRADE AND DEVELOPMENT AGENCY

FORM ADA-2B:
HIPPA-Compliant Release for Psychotherapy Records and Information Concerning Disability and Reasonable Accommodation Request

TO: MY MENTAL HEALTH CARE PROVIDER(S)

In accordance with 45 C.F.R. §§ 164.508(a)(2) and (b)(3)(ii) you are permitted to give the U.S. Trade and Development Agency (USTDA) and any of its employees copies of all my psychotherapy notes since (insert date) . You should give this information regardless of whether it is written, in the form of electronic data on cassette, microfiche, microfilm or any other form. This authorization does not permit you to confer with any employee of USTDA about any substantive matters unless I or my attorney is present.

I am signing this authorization so that USTDA will be able to properly analyze my request for reasonable accommodation. This release is valid and does not expire until the request has been granted or denied and in the latter case, until all appeals processes have ended. I understand that I have the right to revoke this authorization by sending a letter to the Reasonable Accommodations Manager, U.S. Trade and Development Agency, 1101 Wilson Boulevard, Suite 1100, Arlington, VA 22209-3901, requesting that this authorization no longer be used or by directing my attorney to send a letter to the above named person requesting the same on my behalf. In the event that I choose to change my mind and revoke this authorization, I understand that my letter will stop USTDA from requesting additional records with this release and sharing the records with others involved in evaluating my reasonable accommodation request, only after receipt of my letter. Finally, I understand that my treatment, payment, enrollment in any health plan, or eligibility for benefits may not be and are not conditioned upon my agreeing to sign this authorization. USTDA may only request medical documentation supporting a request for reasonable accommodation when the disability and/or need for accommodation is not obvious. A copy of this authorization shall be as valid as the original thereof.

_____
Print Name of Patient/Employee

_____
Signature Date

_____
Date of Birth