LYNN HOUSING AUTHORITY & NEIGHBORHOOD DEVELOPMENT

REQUEST FOR REASONABLE ACCOMMODATIONS/MODIFICATIONS
RELEASE OF INFORMATION AUTHORIZATION

Applicant/Resident Name:_____ D.O.B._____

Address:_____ Phone Number:_____

Housing Program:_____ Case Rep._____

To: Carly McClain, Reasonable Accommodation Coordinator
Lynn Housing Authority & Neighborhood Development
10 Church Street
Lynn, MA 01902

I am requesting the following reasonable unit modification and/or reasonable accommodation to LHAND policies and/or procedures so that I may have an equal opportunity to use and enjoy a dwelling unit, including public and common areas:

_____

_____

_____

_____

The change that I am requesting will accommodate my disability in the following ways:

_____

_____

_____

_____

Name and Title of Medical Professional: _____

Address: _____

Phone number: _____ Fax number: _____

Email Address: _____

I give permission to the Medical Professional listed above to communicate with the Lynn Housing Authority & Neighborhood Development (LHAND), and to disclose information from their records concerning my care and treatment. This authorization is limited to information necessary to determine whether the accommodation that I am requesting is medically necessary to accommodate my disability, for the reasons that I have described above.

I hereby waive and release the Medical Professional listed above from any liability, which they might otherwise incur, and from any restrictions, which might be imposed upon them by law as the result of such disclosures.

This authorization is valid for sixty (60) days. A photocopy of this authorization shall be as effective as the original.

Applicant/Resident Signature: _____ Date:_____