



State of Alaska

Alaska Department of Corrections

Prisoner ADA Request: Prisoner Information Release

I hereby authorize _____ to provide the medical information requested by the Department of Corrections. The information will be used to evaluate my request for accommodation under the Americans with Disabilities Act of 1990 (ADA).

Prisoner Name (Please print)

Prisoner Number

Signature

Date

Attachments:

___ Form 808.16D "Prisoner ADA Request: Health Care Provider Information"

OR

___ Letter from Department of Corrections requesting provider information