Iowa City and University Heights Corporate residents only

CITY OF IOWA CITY

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Transit Division Disabled Bus Pass Program

Authorization for Release of Information

I authorize my physician, _____, to release information to the City of Iowa City regarding my disability which may qualify me to receive a bus pass entitling me to ride Iowa City Transit for free during off-peak hours. I understand that the City of Iowa City will keep this information confidential and that it will only be used to determine my eligibility for an Iowa City Transit disability pass.

Applicant's Name_____ Phone Number_____

Address_____

Signature_____

All questions must be answered to be considered complete

FOR PHYSICIAN USE ONLY:

Please answer the following questions regarding your patient, named above, to enable the City to determine eligibility for a Transit pass.

Disability means, with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of such individual.

1. **According to this definition, is your patient disabled?**

   Yes_____ No_____

2. **If you answered yes, is the disability permanent or temporary? Permanent_____ Temporary_____ If temporary, what is the expected duration of the disability? _____**

Physician's name_____ Phone number_____

Physician's address_____

Physician's signature_____ Date_____

Office stamp here or attach business card:

If you have any questions regarding this form, please call 319-356-5151 option 2. Please mail or deliver form to Transportation Services 335 E Iowa Avenue Iowa City, IA 52240.

Physician's statement must be filled out and professional verification attached to be considered a complete form.