DISABLED BUS PASS PROGRAM 2018-2020

AUTHORIZATION FOR RELEASE OF INFORMATION

DISABLED BUS PASS PROGRAM
(July 1, 2018-June 30, 2020)
CITY OF CORALVILLE
1512 7TH STREET
CORALVILLE, IOWA 52241

I authorize my physician,_____, to release information to the City of Coralville regarding my disability which qualifies me to receive a bus pass entitling me to ride the City of Coralville Transit for free. I understand the City of Coralville will keep this information confidential and it will only be used to determine my eligibility for the City of Coralville disabled bus pass.

Name:_____

Address:_____

Phone:_____

Signature:_____

FOR PHYSICIAN'S USE ONLY

The City of Coralville offers free transportation on the City of Coralville Transit to disabled persons. The program is intended to provide a Transit pass to persons who have difficulty traveling due to disability. Please answer the following questions regarding your patient, named above, to enable the City to determine eligibility for a Transit pass.

1. **Disability is defined by law as a physical or mental condition of a person which constitutes a substantial handicap.** A person with a positive immunodeficiency (HIV) test result is also deemed to be disabled. According to this definition, is your patient disabled?

   Yes_____ No_____

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

   Duration of Disability_____

Physician's Signature_____ Date_____

Physician's Name (Printed)_____

Physician's Address_____ Phone:_____

Thank you for your assistance. Please feel free to call the City of Coralville at 248-1700 if you have any questions regarding this matter.

For Office Use Only: Pass#_____

Date_____ 3/18