Authorization to Release Medical Information

Make additional copies of this form for each health care provider if more than one. Sign and date all forms and return to:

Southern Illinois University Edwardsville
Accessible Campus Community & Equitable Student Support (ACCESS)
Campus Box 1611
Edwardsville, Illinois 62026-1025
Telephone: 618-650-3726
Fax: 618-650-5691

SIUE EMPLOYEE/PATIENT INFORMATION

_____

Name (please print) *Date of Birth*

_____

Address

_____

City *State* *Zip* *Phone number*

HEALTH CARE PROVIDER INFORMATION

_____

Medical Professional's Signature *Name (please print)* *Date*

_____

Clinic or Company Name *Phone number*

_____

Address *City* *State* *Zip*

AUTHORIZATION AND ACKNOWLEDGEMENT

I have requested an accommodation from Southern Illinois University Edwardsville (SIUE) under the Americans with Disabilities Act (ADA) of 1990. I hereby authorize the ADA coordinator for SIUE to communicate directly with the healthcare provider listed on this form, in order to obtain clarification of issues relating to functional limitations for which I am seeking accommodation. This authorization will automatically end within one year from the date I sign this form.

Employee's Signature _____ Date_____

CONFIDENTIALITY NOTICE: Medical-related information shall be kept confidential and maintained separate from other personnel records. However, supervisors and managers may be advised of information necessary to the determinations they are required to make in connection with a request for an accommodation. Safety and facilities personnel may be informed, when appropriate, if the disability might require emergency treatment or if any specific procedures are needed in the case of fire or other evacuations. Government officials investigating compliance with the ADA may also be provided relevant information as requested.