

St. Cloud State University
ADA Authorization for Release of Medical Information

TO: _____
Name of Medical Provider

Address

City State Zip Code

RE: _____
Name of Patient Birthdate or SSN

Address City State Zip Code

I hereby authorize _____
Medical Provider

to disclose to SCSU Human Resources, or any person who is authorized by my employer to handle medical information for ADA purposes, any information concerning my physical or mental condition, that is necessary to determine whether I have a disability and to determine whether any accommodations can be made.

I also authorize SCSU Human Resources, or any person who is authorized by my employer to handle medical information for ADA purposes, to speak to my treating physician or health care provider directly in regards to any questions he/she may have with respect to my condition that relates to the performance of the essential functions of my job and any accommodations that may be necessary.

I understand that the requested data is for the above-mentioned purposes, and that I may refuse to provide the requested medical information. However, I understand that if I refuse to provide the information, my employer may refuse to provide reasonable accommodation.

This authorization is valid for one year from the date indicated below or upon receipt of my signed written notice to withdraw my consent. A photocopy is as valid as an original.

Signature of Patient

Date