St. Cloud State University

Authorization for Release of Medical Information for Americans with Disabilities Act ("ADA") Reasonable Accommodations

Date:_____

Health Care Provider Name:_____

Health Care Provider Address:_____

Health Care Provider Fax Number:_____

Patient Name:_____

Patient Date of Birth:_____

Patient Address:_____

This form does not cover, and the information to be disclosed should not contain, genetic information. "Genetic Information" includes: information about an individual's genetic tests; information about genetic tests of an individual's family members; information about the manifestation of a disease or disorder in an individual's family members (family medical history); an individual's request for, or receipt of, genetic services, or the participation in clinical research that includes genetic services by the individual or a family member of the individual; and genetic information of a fetus carried by an individual or by a pregnant woman who is a family member of the individual and the genetic information of any embryo legally held by the individual or family member using an assisted reproductive technology.

I, _____ [Name of Patient], authorize_____ [Name of Healthcare Provider] to disclose to _____ [Name of Agency ADA Coordinator or designee] or any other person who is authorized by [Name of Agency] to receive medical information that is specifically related and necessary to determine whether I have a disability and whether accommodations can be made. I authorize_____ [Name of Agency ADA Coordinator or designee], or others as authorized by [Name of Agency], to speak to my treating health care provider directly in regards to any questions with respect to my condition as it relates to the performance of the essential functions of my job and any accommodations that may be necessary, to the extent that it will assist [Name of Agency] to make a decision related to my request for accommodation(s) in a timely manner. The persons allowed by this Authorization are only authorized to request information from my treating health care provider that is job-related and does not include genetic information.

I understand that the requested information is for the above-mentioned purposes only. I understand that I may refuse to sign this Authorization. However, I understand that if I refuse to sign this Authorization, I am responsible to ensure [Name of Agency] receives the requested medical information. I also understand that this information shall remain confidential, available only under limited conditions specified under law.

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.

Patient Signature:_____

Date:_____