Tufts UNIVERSITY

Office of Equal Opportunity

Accommodation Authorization for Release of Medical Information

TO:

_____
Printed Name of Medical Provider

_____
Address

_____
City State Zip Code Telephone Number

RE:

_____ _____
Name of Patient Date of Birth

_____
Address

_____
City State Zip Code

_____
Home Telephone Number

I, _____ authorize my Medical Provider to disclose to **Tufts University**, Office of Equal Opportunity, the requested information concerning my medical condition, to be used solely for the purpose of evaluating my request for a reasonable accommodation under Tufts Accommodations Policies. This letter further authorizes OEO to speak to my treating physician or health care provider directly in regards to any questions they may have with respect to my condition that relates to accommodations which 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 also understand if I refuse to provide the information, Tufts University may refuse to provide reasonable accommodation.

_____ _____
Patient/Requester Signature Date

Office of Equal Opportunity

Attention Medical Practitioner:

The individual named below has indicated that they have a disability and will require reasonable accommodation(s) to participate in a program or activity at Tufts University. In order for Tufts to proceed, we require additional information about the individual's medical condition. We are enclosing with this a medical form (Accommodation Authorization for Release of Medical Information) so that they are fully informed of what we are asking and can approve the release of the information needed.

The Americans with Disabilities Act (ADA) requires the provision of reasonable accommodations to Tufts Community members, including visitors, patients and other members of the public who come to the campuses, who are disabled (i.e. have a medical condition that substantially limits a major life function). We are requesting the following information to determine if the individual is covered under the ADA, and if so, an explanation of the nature of the condition specific to which major life activities the condition limits. In addition, please advise us regarding what accommodations you believe the individual needs in order to be provided full access and participation during their visit to Tufts University. The individual should describe the details of their visit with you and make known to you any accommodations they are seeking.

Please return the completed signed forms or send them by fax (please adhere to HIPAA regulations and call before faxing) to Tufts University, Office of Equal Opportunity, at the following address/fax number:

Tufts University
Office of Equal Opportunity
196 Boston Avenue, Suite 4000B
Medford, MA 02155
Fax: 617.627.3075 Phone: 617.627.3298

If you have any questions or concerns about this form, please contact the Tufts Accommodations Team at Accommodations.OEO@tufts.edu.

1. **Patient Name:** _____

2. **Nature of patient's condition(s):** _____

   _____

3. **Date of onset of condition(s):** _____

4. **Current status of condition(s): (e.g. Active, Progressing, Controlled, In Remission):** _____

   _____

5. **How long is this condition(s) likely to exist (be as specific as possible: e.g., lifetime, one year; six months; one month):** _____

   _____

6. **Does the condition(s) affect a major life activity? Yes [ ] No [ ]**

   If yes, what major life activity(s) is/are affected?

[ ] Caring for Self	[ ] Walking	[ ] Hearing	[ ] Standing
[ ] Seeing	[ ] Sleeping	[ ] Reaching	[ ] Speaking
[ ] Breathing	[ ] Toileting	[ ] Learning	[ ] Working
[ ] Lifting	[ ] Reproduction	[ ] Concentrating	
[ ] Performing Manual Tasks		[ ] Interacting with Others	

   [ ] Other: (describe): _____

   Is the individual substantially limited in one or more of these major life areas? Yes [ ] No [ ]

7. **What limitations does this person experience as a result of their disability?**

   _____

   _____

   _____

8. **What is the reason for this person's visit to Tufts University?**

   _____

   _____

   _____

9. **Which Tufts University campus is the individual visiting?**
   - **[ ] Medford/Somerville**
   - **[ ] Grafton**
   - **[ ] Boston**
   - **[ ] SMFA**
   - **[ ] Satellite Clinic or campus (Location: _____)**
   - **[ ] Virtual visit or event (Web Ex, Zoom, Teams, Event Streaming, etc.)**

10. **What is the date and duration of the visit? If it will be a recurring visit (i.e. for medical appointments) please also include anticipated frequency of visits.**

_____

_____

11. **What accessibility barriers might this person experience while visiting Tufts?**

_____

_____

12. **Please state possible reasonable accommodations you believe are necessary for this person to access Tufts.**

_____

_____

_____

Printed Name of Medical Professional: _____

License #: _____ **State:** _____

_____

Address:

_____

City, State, Zip

_____

Telephone **Fax**

_____

Signature **Date:**

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Confidential Fax: 617.627.3075
Email: Accommodations.OEO@tufts.edu
Mail: 196 Boston Avenue, Suite 4000B, Medford, MA 02155