



ADA Authorization for Release of Medical Information

TO:

Printed Name of Medical Provider

Address

City State Zip Code

Telephone Number

RE:

Name of Patient/Student

Date of Birth

Address

City State Zip Code

Home Telephone Number

Email Address

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 the ADA. This letter further authorizes OEO to speak to my treating physician or health care provider directly in regards to any questions s/he may have with respect to my condition that relates to my request for accommodations.

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, the University may refuse to provide reasonable accommodation.

Patient Signature/Tufts University Student

Date

Attention Medical Practitioner:

The student 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 student's medical condition. We are enclosing with this a medical form (ADA Authorization for Release of Medical Information) so that the student is fully informed of what we are asking and can approve the release of the information needed.

The American with Disabilities Act requires the provision of reasonable accommodations to those 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 student 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. The information that you provide will be used to better understand the nature, severity and treatment plan for the student's diagnosis and the appropriateness of requested accommodations or services. Please note that the information you provide must be current; in general, you must have seen the student within the last 6 months to meet this requirement. If you have recently begun treating this student you may find that you do not yet have sufficient information to respond to the questions on this form. If you have not had recent clinical contact with the student, or otherwise find that you cannot effectively complete this form, please inform the student directly. Please make sure to complete this form in its entirety.

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

If you have any questions or concerns about this form, please contact either Amin Fahimi Moghadam, Accommodations Specialist, via email or phone (Amin.Fahimi_Moghadam@tufts.edu or 617-627-3075) or Katherine Vosker, Accommodations Manager and 504 Officer, via email or phone (katherine.vosker@tufts.edu or 617-627-0657).

1. Student/Patient Name: _____

2. Date of your last clinical contact with the student/patient: _____

3. Medical Diagnosis(es) and DSM or ICD-10 Code: _____

3. Date of onset of condition(s) and diagnosis: _____

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?

- | | | | |
|---|---------------------------------------|--|-----------------------------------|
| <input type="checkbox"/> Caring for Self | <input type="checkbox"/> Walking | <input type="checkbox"/> Hearing | <input type="checkbox"/> Standing |
| <input type="checkbox"/> Seeing | <input type="checkbox"/> Sleeping | <input type="checkbox"/> Reaching | <input type="checkbox"/> Speaking |
| <input type="checkbox"/> Breathing | <input type="checkbox"/> Toileting | <input type="checkbox"/> Learning | <input type="checkbox"/> Working |
| <input type="checkbox"/> Lifting | <input type="checkbox"/> Reproduction | <input type="checkbox"/> Concentrating | |
| <input type="checkbox"/> Performing Manual Tasks | | <input type="checkbox"/> Interacting with Others | |
| <input type="checkbox"/> Other: (describe): _____ | | | |

Is the student substantially limited in one or more of these major life areas?

Yes [] No []

7. Please describe how the substantially limiting symptoms impact the student's functioning for academic/clinical abilities (consider higher education academic environments i.e. classroom, navigating campus, assignments, clinic/laboratory work)

8. Please describe the student's history of difficulties with their disability. Include both general and academic areas of impact.
