ADA 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 my employer, **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 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.

_____ _____
Patient Signature/Tufts University Employee Date

Attention Medical Practitioner:

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

The American with Disabilities Act requires employers to provide reasonable accommodations to employees 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 employee 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 employee needs in order to perform his/her duties and responsibilities. I have asked the employee to send along a copy of his/her job description as well and to make known to you any accommodations he/she is 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

If you have any questions or concerns about this form, please contact either Amin Fahimi Moghadam, Accommodations Specialist, vie 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. **Patient Name:** _____

2. **Medical Diagnosis:** _____

   _____

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

7. **What limitation(s) is/are interfering with job performance?** _____

   _____

   _____

8. **What job function(s) is the employee having trouble performing because of the limitation(s)? Please review the Job Description provided for assistance.**

   _____

   _____

   _____

9. **How does the employee's limitation(s) interfere with his/her ability to perform the job function(s)?**

10. **Please state any suggestions regarding possible accommodations you believe may be necessary in order for the employee to improve job performance?**

11. **How would your suggestions improve the employee's job performance?**

Printed Name of Medical Professional:_____

License #: **State:**

Address:

City, State, Zip

Telephone **Fax**

Signature **Date:**

Please return completed form to Tufts University Office of Equal Opportunity