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 or medical condition 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 and 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, 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. **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?

[ ] 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 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 functional as well as 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.**

_____

_____

_____

9. **Current treatment and medication regiment (including treating clinicians, frequency of treatment, medications and side effects):**

_____

_____

10. **Severity of symptoms *with* mitigation:** **Mild** **Moderate** **Severe**

11. **Severity of symptoms *without* mitigation:** **Mild** **Moderate** **Severe**

12. **Prognosis of disability with treatment:** **Good** **Fair** **Poor**

13. **What are the frequency and duration of symptoms of the students condition?**
Ongoing **Episodic (if episodic please how often)**

_____

14. **Based on your clinical evaluation, what accommodations do you think this student will need to be an active member of Tufts University while they navigate their disability?**

_____

_____

_____

15. **Please provide any additional information you feel would be useful in determining the nature and severity of the student's disability and any recommendations for other resources the student may benefit from.**

_____

_____

16. **Will you be seeing the student again for their disability?**
No **Yes**

If yes when is the date of your next scheduled appointment? _____

Printed Name of Medical Professional: _____

License #: **State:**

_____

Signature: _____ **Date:** _____

By signing this form you certify you are the person completing it and verify you are not related to the student by blood or marriage. You also confirm all of the information provided is accurate and up-to-date.