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 **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 s/he has 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 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 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
Katherine H. Vosker
Accommodation Manager
196 Boston Avenue, Suite 4011
Medford, MA 02155
Phone: 617-627-0657
Fax: 617-627-3075

If you have any questions or concerns, please call at the number listed above.

Sincerely,

Katherine H. Vosker
Accommodation Manager

1. **Student 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 student 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