



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 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 Americans with Disabilities Act (ADA). 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 the performance of the essential functions of my job and any accommodations which may be necessary.

I understand the requested data is for the above-mentioned purposes and I may refuse to provide the requested medical information. However, I also understand that if I refuse to provide the information, my employer may refuse to provide reasonable accommodation.

\_\_\_\_\_  
Patient Signature/Tufts University Employee

\_\_\_\_\_  
Date



**Office of Equal  
Opportunity**

Attention Medical Practitioner:

The staff/faculty member named below has indicated they have 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 (Accommodation Authorization for Release of Medical Information) so the employee is fully informed of what we are asking and can approve the release of the information needed.

The American with Disabilities Act (ADA) 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 their job duties and responsibilities. It may be helpful for you to ask the employee's about their job responsibilities and/or job description, and have them 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](mailto: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?

<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 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)?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

---

---

---

---

**10. Please state any possible reasonable accommodations you believe are necessary in order for the employee to perform the essential functions of their job.**

---

---

---

---

**11. How would these accommodation recommendations improve the employee's ability to perform their job functions?**

---

---

---

**Printed Name of Medical Professional:** \_\_\_\_\_

**License #:** \_\_\_\_\_ **State:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City, State, Zip** \_\_\_\_\_

**Telephone** \_\_\_\_\_ **Fax** \_\_\_\_\_

**Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_