



Provider Information/Authorization to Release Medical Information

INSTRUCTIONS FOR EMPLOYEE: Please complete the health care provider information and sign the authorization release below. Make additional copies of this form for each of your health care providers (if you have more than one provider). Please return this form to Human Resources.

HEALTH CARE PROVIDER INFORMATION

Attending Health Care Provider's Name: _____

Attending Health Care Provider's Specialty: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: () _____ Fax Number: () _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

- 1. I have requested an accommodation from the University of Dallas under The Americans with Disabilities Act Amendments Act (ADAAA).*
- 2. Under HIPAA's privacy rules, an authorization allows the use and disclosure of protected health information (PHI) both by the covered entity requesting the authorization and a third party.*
- 3. I hereby authorize University of Dallas Human Resources to communicate directly to the health care provider listed on this form, in order to obtain clarification of issues relating to the functional limitations for which I am seeking an accommodation.*
- 4. I understand that I have the right to revoke this authorization at any time by notifying the University of Dallas in writing. I understand that the revocation is only effective after it is received and logged by the University. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.*
- 5. I understand that my initial and continued employment and position are subject to my agreement to this authorization, and any additional authorization the University requests.*
- 6. I understand that I am entitled to receive a copy of this authorization.*
- 7. I understand that this authorization will expire when my employment with the University terminates. This authorization will automatically end within one year from the date that I sign this form.*

Employee's Signature: _____ Date: _____

CONFIDENTIALITY NOTICE: Medical-related information shall be kept confidential and maintained separate from other personnel records. However, supervisors and managers may be advised of information necessary to the determinations they are required to make in connection with a request for an accommodation. First aid and safety personnel may be informed, when appropriate, if the disability might require emergency treatment or if any specific procedures are needed in the case of fire or other evacuations. Government officials investigating compliance with the ADAAA may also be provided relevant information as requested.

