

FURMAN UNIVERSITY
EMPLOYEE'S AUTHORIZATION
FOR RELEASE OF ADA MEDICAL INFORMATION

Directions:

Read the authorization below. Complete the Provider Information section and the Employee Information section. Sign and date this form and provide a copy to your provider. Scan the form and upload a copy to the Box folder that was created for the purposes of this interactive accommodation process.

AUTHORIZATION TO RELEASE INFORMATION: I authorize the Office of Human Resources at Furman University to receive information from the provider below. Under state and/or federal regulations, and applicable university policy, this information is to be used solely to evaluate my request to determine the existence of an ADA disability and the functional limitations that require reasonable accommodation. A photostatic copy of this authorization is to be considered as valid as the original.

I hereby acknowledge that I have been informed of my right to receive a copy of this authorization request. I further acknowledge that I have been informed that if the medical information contained herein is not released, my reasonable accommodation may be denied.

Provider Information

Name of Provider: _____

Street Address, City, State and Zip Code

Phone Number: _____ Fax Number: _____

Employee Information:

Employee: _____

First Name Middle Name Last Name

Date of Birth: ____/____/____
mm dd yyyy

Address: _____
Street Address, City, State and Zip Code

Signature

Patient/Employee Signature

Date

Revised: August 2024

