Agency Logo

Human Resources / DIVISION / UNIT

**Authorization for Release of Health Care Information under the Americans With Disabilities Act (ADA)**

Employee / Patient information:

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Classification: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Note for HR staff: please delete the highlighted text before having the employee sign this form.**

* Do not require the employee to complete this release, at least initially. If you determine that you do need to get additional information from their health care provider(s), we suggest you
  + Draft the questions to the health care provider and give them to the employee along with: the letter to the doctor; the employee’s ADA request; their position description. Ask the employee to return responses directly to you.
* This approach will:
  + Keep the process transparent (the employee knows what you are asking and the responses from your doctor).
  + Help address confidentiality concerns the employee may have.

**Permission to release limited medical and health information**

I authorize the listed provider(s) to cooperate with **Name, Title** at the **Agency Name** to release limited medical information that helps to evaluate my request for an accommodation under the ADA.

I understand that such contact by the **Agency Name** is only for one or more of the following:

* Identify any limitations or work restrictions associated with the disability, impairment, or medical condition.
* Assess my ability to perform the essential functions of my job.
* Assess my ability to safely perform the duties of my job
* Assess whether accommodations are necessary for me to perform the essential functions of my job.
* Clarify the medical or health information submitted to **Agency Name**.

I understand that any and all medical and health information obtained related to this request will be treated with the strictest of confidence and shared only on an as-needed basis or in accordance with ORS 659A.133.

I understand the information used or disclosed per this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, and treatment or referral information.

I understand that I can refuse to sign this authorization or later revoke my consent by notifying the **Agency** representative in writing at the address listed on this form.

**This authorization expires 180 days after I sign it but I may choose to revoke it at any time.**

**NOTE:** Per the Genetic Information Nondiscrimination Act of 2008 (GINA), this agency is not requesting or requiring its employees or family members to provide genetic information. To comply with this law, please do not provide any genetic information when responding to this request for medical and health information. We are inquiring about the medical condition the employee noted on the Accommodation Request Form in relation to the employee’s request for accommodation. We are assessing whether this individual has an ADA-qualifying impairment. We are not requesting medical records unrelated to the impairment or any unrelated medical history.

The agency is only interested in communicating with the health care provider(s) most familiar with the employee’s specific disability, impairment, or medical condition that is impacting their ability to perform the essential functions of their job.

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| --- | --- |
| **Authorized health care provider(s)** | |
| Health Care Provider 1 | Health Care Provider 2 |
| Provider Name | Provider Name |
| Street Address | Street Address |
| City | City |
| State, Zip Code | State, Zip Code |
| Provider Phone | Provider Phone |
| Provider Fax | Provider Fax |

|  |  |
| --- | --- |
| **Authorized health care provider(s)** | |
| Health Care Provider 3 | Health Care Provider 4 |
| Provider Name | Provider Name |
| Street Address | Street Address |
| City | City |
| State, Zip Code | State, Zip Code |
| Provider Phone | Provider Phone |
| Provider Fax | Provider Fax |

Employee Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_

\* If it is necessary to communicate with the employee’s health care provider(s), this form does need to be signed by the employee.