HEALTH CARE PROVIDERS INFORMATION
CONFIDENTIAL RECORDS STATEMENT
AUTHORIZATION TO RELEASE MEDICAL INFORMATION

INSTRUCTIONS FOR EMPLOYEE: Complete patient information, health care provider information and sign authorization release below. Make additional copies of this form for each of your health care providers, if you have more than one provider.

Sign and date all forms and return to:

West Virginia State University
Human Resources
P.O. Box 1000/105 Cole Complex
Institute, WV 25112
Telephone: 304-766-3156
Fax: 304-766-4156

WVSU EMPLOYEE/PATIENT INFORMATION

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

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

I have requested an accommodation from West Virginia State University (WVSU) under The Americans with Disabilities Act (ADA) of 1990. I hereby authorize the ADA Coordinator for WVSU to communicate directly with 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. This authorization will automatically end within one year from the date I sign this form.

Employee/Patient 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. Safety and facilities 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 ADA may also be provided relevant information as requested.