ATHENS STATE UNIVERSITY

ADA AUTHORIZATION FOR RELEASE OF INFORMATION

1. I give the Human Resources/ADA Office personnel permission **to issue a Medical Inquiry Form to my physician or relevant professional** to verify my disability and need for accommodations. Specifically, I further authorize _____ (medical provider) to disclose to the Human Resources/ADA Office personnel (including any person authorized by my employer to handle medical information for ADA purposes), any information concerning my physical or mental condition that is necessary to determine whether I have a disability and to determine whether any accommodations can be made. I also authorize Human Resources/ADA Office personnel to speak to the above-named 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 that may be necessary. I understand that the requested data is for the above-mentioned purposes, and that I may refuse to provide the requested medical information. However, I understand that if I refuse to provide the information, my employer may refuse to provide reasonable accommodation. This authorization is valid for one year from the date indicated below or upon receipt of my signed written notice to withdraw my consent. A photocopy is as valid as an original.

   NAME:_____
   DEPARTMENT:_____
   DATE:_____
   SIGNATURE:_____

2. I give the Human Resources/ADA Office personnel permission to discuss my disability and need for accommodation **with my Vice President**.
   NAME:_____
   DEPARTMENT:_____
   DATE:_____
   SIGNATURE:_____

3. I give the Human Resources/ADA Office personnel permission **to talk with any medical providers, medical specialists, mental health specialists, or rehabilitation counselors** to clarify issues related to my disability or accommodations that I have requested.
   NAME:_____
   DEPARTMENT:_____
   DATE:_____
   SIGNATURE:_____