FAIRMONT STATE UNIVERSITY

Authorization for Release of Medical Information for Americans with Disabilities Act (“ADA”) Reasonable Accommodations

(Please print unless otherwise indicated.)

The purpose of the Authorization for Release of Medical Information for Americans with Disabilities Act (“ADA”) Reasonable Accommodations (“Authorization” is to obtain information related to your request for reasonable accommodation under the ADA/ADAA and to facilitate the interactive process. Please submit a completed form to hr@fairmontstate.edu. If you are being treated by more than one health care provider, a separate form must be submitted for each.

Date: ______________________________

Health Care Provider Name:____

Health Care Provider Address:____

Health Care Provider Fax Number:________________________________

Patient Name:____

Patient Date of Birth:____

Patient Address:____

This form does not cover, and the information to be disclosed should not contain, genetic information. “Genetic Information” includes: information about an individual’s genetic tests; information about genetic tests of an individual’s family members; information about the manifestation of a disease or disorder in an individual’s family members (family medical history); an individual’s request for, or receipt of, genetic services, or the participation in clinical research that includes genetic services by the individual or a family member of the individual; and genetic information of a fetus carried by an individual or by a pregnant woman who is a family member of the individual and the genetic information of any embryo legally held by the individual or family member using an assisted reproductive technology.

I authorize the above referenced health care provider to disclose to Ashley Maxey or any other person who is authorized by Fairmont State University to receive medical information any information concerning my physical or mental condition that is specifically job related and necessary to determine whether I have a disability and what, if any reasonable accommodations that do not cause an undue hardship may be available. I authorize Ashley Maxey or others as authorized by Fairmont State University, to speak to my treating health care provider directly in regards to any questions with respect to my physical or mental condition(s) as they relate to my functional limitations, the performance of the essential functions of my job and any accommodations that may be necessary, to the extent that it will assist Fairmont State University to make a decision related to my request for accommodation(s) in a timely manner. The persons allowed by this Authorization are only authorized to

request information from my treating health care provider that is job-related and consistent with business necessity and that does not include genetic information.

Disclosures may occur in a variety of ways including but not limited to email, telephone and/or facsimile.

I understand that the reasonable accommodation process requires interactive discussion between all parties involved, and that as part of the interactive accommodation request process, the ADA permits the University to discuss my functional limitations with my immediate supervisor and others to the extent the discussion relates to the performance of the essential functions of my job and the determination of what, if any, effective reasonable accommodations that do not cause an undue hardship may be available.

I understand that the requested information is for the above-mentioned purposes only. I understand that I may refuse to sign this Authorization. However, I understand that if I refuse to sign this Authorization, I am responsible to ensure Fairmont State University receives the requested medical information.

I understand that the University uses and maintains all information obtained during the interactive and accommodation request process in accordance with all applicable State and Federal regulations, including all confidentiality requirements.

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.

Print Employee/Patient Name: ____

Patient/Employee Signature: ____

Date: ____________