Health Information Release Waiver

Employee / Student/ Patient Information

_____

Name (Please Print)

_____

Address

_____

City **State** **Zip Code**

_____ _____

Home Phone Number **Work Phone Number**

Healthcare Provider Information

Name_____ Title_____

Name of Practice (if applicable)_____

Mailing Address_____

Street Address

_____

City State Zip Code

Phone Number (_____) _____

Fax Number (_____) _____

I am requesting reasonable accommodations for my medical condition(s) through my employer/ institution, The University of West Georgia. I give a representative of the Office of Legal Affairs permission to speak with and/or request written information regarding medical assessment(s) on my behalf. I authorize my health care provider to release relevant information regarding my medical condition. I realize that this information will be kept in confidence and will be used only for purposes of determination of reasonable accommodations under the Americans with Disabilities Act (ADA). This release will automatically end within one (1) year from the date I sign this form. I maintain the right to revoke this release at any time with signed written notice to the Office of Legal Affairs.

Employee / Patient Signature: _____

Date: _____