Albert Einstein College of Medicine

Disability Accommodation Health Care Provider Release Form

For Completion by Employee. Please complete this form to authorize your health care provider to disclose information pertaining to your disability accommodations request. Submit this completed form to your certified health care provider, along with copies of the **Disability Accommodations Request Form** and the **Health Care Provider Statement Form**. All information submitted will be kept confidential to the extent permitted by law. Please note: Your request cannot be considered unless **all 3 forms** are completed and sent to: VP Human Resources and Diversity Officer Albert Einstein College of Medicine 1300 Morris Park Avenue, Suite 1209 Bronx, New York, 10461 Fax: (718) 430-8542.

1. Name (Last) (First) (M.I.)		2. Date of Birth:
3. Job Title:	4. Department:	5. Work telephone #:
6. Health Care Provider's Name & Address:		7. Health Provider Telephone #:

8. I have informed my employer, Albert Einstein College of Medicine, that I have the following disability or serious health condition:_____. In order to assist me in performing my job duties, I have requested that Albert Einstein College of Medicine provide me with the following accommodation(s):

_____

_____

_____

I hereby authorize you to disclose to Albert Einstein College of Medicine, and its authorized representatives, any information that is related to my disability as outlined on the attached. I understand that it may be necessary for Albert Einstein College of Medicine to share this information with authorized representatives to the extent necessary to determine whether an accommodation is necessary and to administer the disability accommodations process. I understand that information obtained under this release is confidential and is maintained separate from my personnel file. Furthermore, I understand that I may revoke this consent, in writing, at any time except to the extent that action has already been initiated based on the original authorization.

By signing this release form, I acknowledge that I have read and agreed to the above terms.

9. Employee's Signature:	10. Date: