RELEASE OF MEDICAL INFORMATION
AUTHORIZATION FORM

I, ____________________________ authorize the University of Oregon (UO) ADA Coordinator, or designee, and UO legal counsel to review certain medical records or summaries of records that exist and are authored by the health care provider(s) or staff listed below. This authorization for release is limited to those records or summaries regarding my medical condition as they relate to my UO employment, as reflected in the attached job description and any other supporting documentation. In addition, the same health care provider(s) may provide information to the UO ADA Coordinator, or designee, and UO legal counsel related to specific accommodations that could be made to assist in my ability to perform the essential job functions of my employment position with UO.

I also authorize my health care provider(s) and staff to discuss that medical information and related issues such as my ability to perform the essential functions of my UO employment and possible accommodations for any disability, with the UO ADA Coordinator, or designee, and UO legal counsel. I understand that contact between these individuals is for the purpose of assessing my physical and/or mental condition in relation to the duties that are associated with my university employment, whether such accommodations are warranted, and if so, what form they should take.

This authorization continues from this date until __________________.

Signature: ________________________________ Date: _____________

Healthcare Provider(s) and Staff:

Name:

Address:

Phone Number:

Facsimile Number:

Name:

Address:

Phone Number:

Facsimile Number: