EAST TENNESSEE STATE UNIVERSITY
DISABILITY SERVICES
Box 70605 • Johnson City, Tennessee 37614-1708 • (423) 439-8346 (V/TDD) • (423) 439-8370 (TDD)

Employee Permission to Release Medical/ Mental Health Information

Health Care Provider(s) Contact Information
(Provide information for **all** providers who can document your disability. Include mailing address, telephone and fax numbers.):

_____

_____

_____

I hereby authorize the above-named health care provider(s) to complete this form and disclose to the East Tennessee State University (ETSU) and its authorized representatives the following information related to my health care:

- diagnosis of relevant conditions and treatment plan
- my ability to perform my work
- recommendations, medical history, reports and correspondence.

I understand that it may be necessary for ETSU representatives to share this information for purposes related to accommodation of a disability. I authorize ETSU to share this information among **appropriate staff and authorized representatives** to the extent necessary to determine whether accommodation is necessary and to administer the accommodation process.

I understand that I have the following rights:

- to inspect or receive a copy of my protected health information
- to receive a copy of this signed authorization
- to refuse to sign this authorization.

I understand that information obtained under this release is a confidential medical record and is maintained separate from my personnel file.

This authorization is valid for the duration of my employment at ETSU. I understand that I may revoke this consent, in writing, at any time except to the extent that action has already been taken based on the original authorization.

_____ _____
Employee Signature Date

_____
Printed Name

_____ _____
ADA Coordinator Signature Date

_____
ADA Coordinator Printed Name