UCONN HEALTH

16 Munson Road, 5th Floor
Farmington, CT 06032
Telephone 860-679-2831
Facsimile 860-679-1051

Authorization for Disclosure and Release of Medical Information Form

As required by Connecticut law, the Department of Human Resources may not use or disclose your individually identifiable information without your authorization.

Your completion of this form means that you are giving permission for the use(s) and disclosure described below.

Please review and complete this form carefully. It may be invalid if not fully completed.

Please forward this form, along with the Request for Reasonable Accommodation Form to the Department of Human Resources upon completion.

HR USE ONLY

I, _____ [employee's name] whose home address is

_____

and whose date of birth is _____HEREBY AUTHORIZE

_____

[provider's name, address, phone and fax]

to release medical information pertinent to the reasonable accommodation I requested to:

FOR UCONN HEALTH:
ADA Accommodations Case Manager
UConn Health
P.O. Box 4035
Farmington, CT 06034-4035
Telephone - (860) 679-2831
Facsimile - (860) 679-1051

To any licensed physician, other licensed practitioner, hospital, clinic, or other medically related facility, or United States Veteran Administration:

I authorize you to release to the Department of Human Resources information to be used solely for the purpose of evaluating my request for reasonable accommodation. The information being requested relates only to any condition that affects my ability to perform my essential job functions. The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, do not provide any genetic information when responding to this request for medical information.
Initial _____

This Authorization shall be valid for a period of 180 days after the date of my signature or earlier if revoked by me in writing to the Department of Human Resources.
Initial _____

ACKNOWLEDGEMENT

I understand that the Department of Human Resources may not use or disclose my medical information except for the expressed purposes identified above, unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

I understand that once this information is disclosed pursuant to this Authorization, it is no longer protected by the Department of Human Resources privacy policies, and may possibly be re-disclosed by the recipient.

I hereby acknowledge that I have been informed of my right to receive a copy of this authorization request.

I acknowledge that I have the right to refuse to sign this Authorization.

I acknowledge that I may revoke this Authorization in writing at any time. I understand that if I revoke this Authorization, the information described above may no longer be used or disclosed for the purpose described in this written Authorization. To revoke this Authorization, please send a written statement to:

ADA Accommodations Case Manager
UConn Health, Human Resources
P.O. Box 4035
Farmington, CT 06034-4035

My signature below indicates that I have read and understand this Authorization and its terms.

_____ _____
Signature Date

Revised 2/19