University Of Michigan

Health Care Provider Release Form

Your First and Last Name

University of Michigan Identification Number

Name of Health Care Provider

Provider Address

Provider Phone Number

I authorize my health care provider and give them permission to release information to the University of Michigan and its representatives to advise the University about my abilities in relation to my appointment and associated responsibilities. I understand that the University will provide my Health Care Provider with specific information about my appointment, including the essential functions and specific requirements. All information obtained will be maintained and used in accordance with the Americans with Disabilities Act of 1990 confidentiality requirements, and all other applicable laws.

This release may be revoked at any time. It shall be valid no longer than is reasonably necessary to accomplish the purpose for which it was given. This release becomes effective on the date of signature and expires automatically in one year, unless otherwise revoked in writing.

Your Signature

Date

Send a copy of this completed document, along with all associated documents to:

University of Michigan
Darlene Ray-Johnson, Rackham Accessibility Facilitator
Rackham Graduate School, Suite 1100
915 E. Washington St.
Ann Arbor, MI 48109-1070
Phone: (734) 936-1647
Fax: (734) 763-2447 (fax)
E-mail: rayj@umich.edu