



**REASONABLE ACCOMMODATION  
HEALTH CARE PROVIDER RELEASE FORM**  
(THIS FORM TO BE COMPLETED BY THE EMPLOYEE/APPLICANT)

Complete this form to authorize your Health Care Provider to disclose information related to your request. Submit this completed form to your certified Health Care Provider, along with copies of the Reasonable Accommodation Request Form and the Health Care Provider Statement Form.

<b>SECTION 1 - APPLICANT/EMPLOYEE INFORMATION</b>	
<b>Name:</b> _____	<b>DOB:</b> _____
<b>Address:</b> _____	<b>Phone #:</b> _____
	<b>Email:</b> _____
<b>SECTION 2- HEALTH CARE PROVIDER INFORMATION</b>	
<b>Name:</b> _____	
<b>Practice/Specialty:</b> _____	
<b>Address:</b> _____	<b>Phone #:</b> _____
<b>SECTION 3 – ACCOMMODATION REQUESTED</b>	
<b>I have informed Yeshiva University that I need a reasonable accommodation for the following disability, health condition or reason:</b> _____.	
In order to assist me in performing my job duties or applying for employment, I have requested that the University provide me with the following accommodation/s:	
1. _____	
2. _____	
3. _____	
I hereby authorize you to disclose to Yeshiva University, and its authorized representatives, any information that is related to my disability or health condition.	
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.	

**Employee/Applicant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_