

**YESHIVA UNIVERSITY
DISABILITY ACCOMMODATIONS
HEALTH CARE PROVIDER RELEASE FORM**

For Completion by Employee. Please complete this form to authorize your health care provider to disclose information pertaining to your disability accommodations request. Submit this completed form to your certified health care provider, along with copies of the **Disability Accommodations Request Form** and the **Health Care Provider Statement Form**. All information submitted will be kept confidential to the extent permitted by law. **Please note: Your request cannot be considered unless all forms are completed.** Send all completed forms to:

**University Benefits Office
Yeshiva University, 2495 Amsterdam Avenue, Belfer Hall, New York, NY 10033**

1. Name (Last)	(First)	(M.I.)	2. Date of Birth:
3. Job Title:	4. Department:		5. Work telephone #:
6. Health Care Provider's Name & Address:			7. Health Provider Telephone #:

8. I have informed my employer, Yeshiva University, that I have the following disability or serious health condition: _____ . In order to assist me in performing my job duties, I have requested that the University provide me with the following accommodation/s:

I hereby authorize you to disclose to Yeshiva University, and its authorized representatives, any information that is related to my disability as outlined on the attached. I understand that it may be necessary for the University to share this information with authorized representatives to the extent necessary to determine whether an accommodation is necessary and to administer the disability accommodations process. I understand that information obtained under this release is confidential and is maintained separate from my personnel file. 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.

By signing this release form, I acknowledge that I have read and agreed to the above terms.

9. Employee's Signature:	10. Date:
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