Release of Information Form

I, ______________________________________, believe that I have a medical condition that may require an accommodation to allow me to perform the essential functions of my position as ____________________________________ at The George Washington University (GW).
Job Title

I hereby authorize my health care provider(s)* who have treated me for my medical condition to provide information to GW relevant to the assessment of whether I am entitled to a reasonable accommodation under the Americans with Disabilities Act.

My health care provider(s) may identify my medical condition that prevents me from performing the essential functions of my job. My health care provider(s) may also discuss and/or release documents which show how the medical condition limits my ability to perform my job, the extent to which I would be able to perform the essential functions of my job with an accommodation, the nature of any such accommodation and the probable duration of the condition.

This release is granted with the understanding that all medical information obtained will be handled in confidence, in accordance with applicable laws. A photographic copy of this authorization shall have the same validity as the original.

*My health care provider(s) is/are ____________________________________and can be
Name

reached at________________________. His/Her fax number is ______________________.
Phone Number Fax Number

____
Employee Signature *Date*

____
GWID

EEOA Receipt Date

Please submit to EEOA office by email at accommodations@gwu.edu or fax 202-994-9658.