University of New Hampshire

HEALTHCARE PROVIDER RELEASE FORM

I, ____ give the University of New Hampshire permission
(Your Name)

to contact ____.
(Healthcare Provider's Name)

I understand the reason for this contact is to advise the University of New Hampshire about my functional abilities and limitations in relation to my job functions. I understand that the University of New Hampshire will provide ____________________________________with specific information about
(Healthcare Provider's Name)

my job position, including the essential functions and specific requirements. All information obtained from medical examinations and inquiries will be maintained and used in accordance with the Americans with Disabilities Act of 1990 (ADA) confidentiality requirements.

Date: ____________________________

Your signature: _________________________________ **Your Birth Date:**__________________________

Healthcare Provider Name, Title and Address:

Name & Title: ____

Address: ____

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Phone: _____________________ **Fax:** ______________________

Print and sign this form*. *Submit it to the EEO/ADA Compliance Officer, Affirmative Action and Equity Office, 105 Main Street, Thompson Hall 305, Durham, NH or fax to 603.862-2936