THE UNIVERSITY of TULSA

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Authorization for Release of Medical Information
Pursuant to HIPAA, 45 CFR Parts 160 and 164

Provider Name: _____ ("Provider")

I hereby authorize Provider to furnish my employer, The University of Tulsa (the "University"), and its representatives, in response to the attached questionnaire of the University related to my request for workplace accommodations. I understand that this Authorization provides for the release of health information, including information concerning medications I have been prescribed and the diagnosis and treatment of mental or psychological health, to the extent they are relevant to my request for workplace accommodations.

I provide this authorization related to any treatment from January 1, 2020 to the present.

I understand that information used or disclosed pursuant to this Authorization may be re-disclosed by the University and/or its representatives and may no longer be protected by federal or state law. I understand that except to the extent that action has already been taken in reliance on this Authorization, I can revoke this Authorization at any time by submitting a notice in writing to the University, attention Dr. Tawny Rigsby. Unless revoked or otherwise specified, this Authorization will expire one (1) year from the date signed. I agree that a photocopy of this authorization will be valid as an original.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, the University asks that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

_____ _____
Date Printed Name of Patient

_____
Signature of Patient or Representative

Date of Birth: _____

Job Title: _____

Department: _____

Health Care Provider Questionnaire

Dear Provider:

Your patient has requested an accommodation to assist with performing the essential functions of his/her position with our organization. In order to assist with the interactive process, we are requesting you to provide the following information based on your medical expertise. **Please limit your responses to the condition for which the employee is seeking accommodation.** Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of your patient.

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To Be Completed by Employee:

Employee Name: _____

Employee Job Title: _____

Employee Department: _____

Employee's Work Schedule: _____

Employee Date of Birth: _____

**** Employee, please provide a copy of your job description to your health care provider.**

To Be Completed by Provider:

Date: _____ *Please attach a business card.*

Provider's Name (printed): _____

Provider's Business/Practice Name: _____

Provider's Business Address: _____

Type of Practice / Medical Specialty: _____

Telephone: (____) _____

Fax: (____) _____

1. Please confirm that you have examined the employee and are familiar with the employee's medical condition(s).

   ☐ Yes ☐ No

2. Please confirm that you have reviewed the job description for the employee.

   ☐ Yes ☐ No

3. Is the employee able to perform the essential functions of their position without the need for accommodation(s)?

   ☐ Yes ☐ No

*** If "No" to Question 3, please continue to the following question:**

4. Does the employee have a physical or mental impairment?

   ☐ Yes ☐ No

   If yes, please describe the nature of the impairment. *Please do not provide information regarding any condition for which the employee does not require an accommodation.*

   _____

   _____

   _____

   _____

*** If "Yes" to Question 4, please continue to the following question:**

5. Does the employee's physical or mental impairment substantially limit a major life activity as compared to most people in the general population?

   ☐ Yes ☐ No

   If yes, please describe the limitations to the employee's major life activities, and the expected duration. *Please do not provide information regarding any condition for which the employee does not require an accommodation.*

*** If "Yes" to Question 5, please continue to the following questions:**

6. Is the employee unable or limited in their ability to safely perform any of the essential functions of their job as listed in the position description because of the medical impairment identified above? If so, please identify the functions or activities you believe are limited and describe the nature, duration, and severity of such limitation(s).

7. If you believe that the employee requires accommodation(s) to perform the essential functions of their job, or to do so safely, please provide suggestions of possible accommodations you believe should be considered and estimate the duration that such accommodation(s) may be required. If a leave of absence or alternate work schedule is suggested, please provide details regarding the leave or alternate schedule suggested, including the anticipated duration of such request. *Kindly provide a description of all alternative accommodations that you believe may exist.*

8. Please provide any additional information that you believe will assist the University in determining, in consultation with the employee, whether an accommodation can reasonably be provided to permit them to perform the essential functions of their position. We stress that you should not provide information that would provide us with information that should not be disclosed under GINA.

_____

_____

_____

_____

Dated: _____ Provider Signature: _____

Please return this form to Dr. Tawny Rigsby, ADA Coordinator:

Dr. Tawny Rigsby
ADA Coordinator and Compliance Officer
McClure Hall, Room 104
800 South Tucker Drive
Tulsa, OK 74104
Fax: 918-631-3459