

HEALTH CARE PROVIDER RELEASE FORM

I, _____ employee/applicant), give Central Connecticut State University permission to contact _____ (health care provider). I understand the reason for this contact is to advise the University about my functional abilities and limitations in relation to my job functions. I understand that the University will provide _____ (health care provider) with specific information about the position, including the essential functions and specific requirements. All information obtained from employee medical examinations and inquiries will be job-related and consistent with business necessity. All information obtained will be maintained and used in accordance with the Americans with Disabilities Act of 1990 confidentiality requirements, and all other applicable State and Federal laws.

Employee/Applicant Signature

Date