SYRACUSE UNIVERSITY
EQUAL OPPORTUNITY, INCLUSION,
AND RESOLUTION SERVICES

Health Care Provider Release Form

I, ______________________________ ("Employee"), give Syracuse University permission to contact __________________________ ("Health Care Provider"). I understand the reason for this contact is so that my Health Care Provider may advise Syracuse University about my functional abilities and limitations in relation to my job functions. I understand that Syracuse will provide my Health Care Provider with specific information about my job position, including the essential functions and specific requirements of the job. I authorize my Health Care Provider to disclose my health information related to my functional abilities and limitations in relation to my job functions to Syracuse University as my employer, and that such health information may include, without limitation, HIV-related, alcohol or drug treatment, or mental health treatment information.

Date ________________________________

Employee ____________________________

Witness _____________________________

Address of Health Care Provider: Phone Number:

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