SYRACUSE UNIVERSITY
EQUAL OPPORTUNITY, INCLUSION,
AND RESOLUTION SERVICES

Healthcare 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 Healthcare Provider may advise Syracuse University about my functional abilities and limitations in relation to my job functions. I understand that Syracuse will provide my Healthcare Provider with specific information about my job position, including the essential functions and specific requirements of the job. I authorize my Healthcare 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 Healthcare Provider: Phone Number:

_____ _____

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