TEXAS
The University of Texas at Austin

Authorization to Release Medical Information

I,_____, authorize the University's ADA Coordinators (Dr. Jennifer Maedgen/Stephanie Myers) to communicate with my licensed healthcare provider listed below. The purpose of this authorization is to assist my employer, the University of Texas at Austin, in evaluating the need for workplace accommodations.

I authorize my licensed healthcare provider listed below to provide information to the University's ADA Coordinators that will assist the University in making a determination regarding my request for workplace accommodations.

I understand that I may revoke this authorization at any time by notifying in writing the University's ADA Coordinators, but if I do, it will not have any effect on actions the University took in reliance on this authorization prior to receiving the revocation. This authorization expires if the employee no longer seeks workplace accommodations under the Americans with Disabilities Act, as amended or leaves employment with the University.

Contact Information for my Licensed Healthcare Provider:

_____
Healthcare Provider's Name

_____
Healthcare Provider's Mailing Address

_____
Healthcare Provider's Telephone Number Fax Number

_____
Employee Signature **Date**

This form can be submitted:

- Via email at: equity@utexas.edu
- By fax at: 512-471-8180
- If you have questions, please contact: Stephanie Myers, Deputy ADA Coordinator at 512-471-7107 or smyers@austin.utexas.edu