Authorization for Release of Medical Information for American's with Disabilities ("ADA") Reasonable Accommodations

Date:_____

Health Care Provider Name:_____

Health Care Provider Address:_____

Health Care Provider Fax Number:_____

Patient Name:_____

Patient Date of Birth:_____

Patient Address:_____

This form does not cover, and the information to be disclosed should not contain, genetic information. "Genetic Information" includes: information about an individual's genetic tests; information about genetic tests of an individual's family members; information about the manifestation of a disease or disorder in an individual's family members (family medical history); an individual's request for, or receipt of, genetic services, or the participation in clinical research that includes genetic services by the individual or a family member of the individual; and genetic information of a fetus carried by an individual or by a pregnant woman who is a family member of the individual and the genetic information of any embryo legally held by the individual or family member using an assisted reproductive technology.

I, _____ [Name of Patient], authorize _____ [Name of Healthcare Provider] to disclose to Amanda Korynta, ADA Coordinator or any other person who is authorized by Minnesota State University Moorhead to receive medical information that is specifically related and necessary to determine whether I have a disability and whether accommodations can be made. I authorize Amanda Korynta, ADA Coordinator, or others as authorized by Minnesota State University Moorhead, to speak to my treating health care provider directly in regards to any questions with respect to my condition as it relates to the performance of the essential functions of my job and any accommodations that may be necessary, to the extent that it will assist Minnesota State University Moorhead to make a decision related to my request for accommodation(s) in a timely manner. The persons allowed by this Authorization are only authorized to request information from my treating health care provider that is job-related and does not include genetic information. I understand that the requested information is for the above-mentioned purposes only. I understand that I may refuse to sign this Authorization. However, I understand that if I refuse to sign this Authorization, I am responsible to ensure Minnesota State University Moorhead receives the requested medical information. I also understand that this information shall remain confidential, available only under limited conditions specified under law.

This Authorization is valid for one year from the date indicated below or upon receipt of my signed written notice to withdraw my consent. A photocopy is as valid as an original.

Patient Signature: _____

Date: _____

Letter Requesting Documentation for Determining American's with Disabilities ("ADA") Eligibility from a Medical Provider

MINNESOTA STATE UNIVERSITY MOORHEAD

Genetic Information Nondiscrimination Act of 2008 Disclosure: This form does not cover, and the information to be disclosed should not contain, genetic information. "Genetic Information" includes: information about an individual's genetic tests; information about genetic tests of an individual's family members; information about the manifestation of a disease or disorder in an individual's family members (family medical history); an individual's request for, or receipt of, genetic services, or the participation in clinical research that includes genetic services by the individual or a family member of the individual; and genetic information of a fetus carried by an individual or by a pregnant woman who is a family member of the individual and the genetic information of any embryo legally held by the individual or family member using an assisted reproductive technology.

Date: _____

To: _____

Health Care Provider Name and Address

RE: _____

Employee Name and Date of Birth

HEALTH CARE PROVIDER INSTRUCTIONS:

The above employee has requested a reasonable accommodation under the Americans with Disabilities Act ("ADA"), as amended, to enable the employee to perform their job duties or access an employment benefit. The information requested on this form will assist us in making a determination regarding the employee's request.

Please complete each section of the following form, and sign and date the form. Attach additional pages as needed. Do not provide information not related to the employee's ability to perform their job duties or access an employment benefit. For example, do not identify the impairment if it does not have an impact on the employee's ability to do their job or to access an employment benefit. **Do not send copies of medical records.** We are not authorized to have medical records and are not qualified to interpret them.

QUESTIONS TO HELP DETERMINE WHETHER THE EMPLOYEE HAS A DISABILITY.

Existence of impairment: For reasonable accommodation under the ADA, the employee has a disability if they have a physical or mental impairment that substantially limits one or more major life activities or a record of such impairment.

1. Does the employee have a physical or mental impairment?
    a. Answer yes or no:

    b. If yes, what is the impairment?

2. Does the employee have a record of a substantially limiting impairment and needs a reasonable accommodation related to a past disability?
    a. Answer yes or no:

    b. If yes, what was the impairment?

Limitations on major life activities: Answer the following question based on what limitations the employee has when their condition is in an active state and what limitations the employee would have without regard to the ameliorative effects of any mitigating measures. (The ADAAA prohibits consideration of the ameliorative effects of mitigating measures when assessing whether an impairment substantially limits a major life activity. This means, for example, the ameliorative effects of the insulin a person uses must NOT be considered when determining whether that person's diabetes is a disability.) Mitigating measures include, but are not limited to, things such as medication, medical supplies, equipment, hearing aids, mobility devices, assistive technology, auxiliary aids or services, prosthetics, etc. One exception to this rule is the use of ordinary eyeglasses or contact lenses. You should consider the ameliorative effects of ordinary eyeglasses or contact lenses in determining whether an impairment substantially limits a major life activity.

1. Does the impairment substantially limit a major life activity as compared to most people in the general population? Answer yes or no:

2. If yes, circle the affected major life activity(s) and major bodily function(s):

   Major Life Activities:

Bending	Learning	Sleeping
Breathing	Lifting	Speaking
Caring for Self	Performing Manual Tasks	Standing
Concentrating	Reaching	Thinking
Eating	Reading	Walking
Hearing	Seeing	Working
Interacting with Others	Sitting	Other

   If other, please describe:

   Major Bodily Functions:

Bladder	Genitourinary	Operation of an Organ
Bowel	Hemic	Respiratory
Brain	Immune	Reproductive
Cardiovascular	Lymphatic	Special Sense Organs
Circulatory	Musculoskeletal	Other
Digestive	Neurological	
Endocrine	Normal Cell Growth	

   If other, please describe:

3. Describe the nature, severity and anticipated duration of the impairment:

   Temporary (explain):

   Temporary with residual side effects (explain):

   Chronic (explain):

   Permanent (explain):

   Anticipated duration:

QUESTIONS TO HELP DETERMINE WHETHER AN ACCOMMODATION IS NEEDED.

An employee with a disability is entitled to an accommodation only when the accommodation is needed because of the disability. The following questions may help determine whether the requested accommodation is needed because of the disability.

1. What limitation(s) is interfering with job performance or accessing a benefit of employment?

2. What job functions or benefits of employment is the employee having trouble performing or accessing because of the limitation(s)?

3. How does the employee's limitation(s) interfere with his/her ability to perform the job function(s) or access a benefit of employment?

An individual with a record of a substantially limiting impairment may be entitled, absent undue hardship, to a reasonable accommodation if needed and related to the past disability.

1. What past limitation(s) is interfering with job performance or accessing a benefit of employment?

2. What job functions or benefits of employment is the employee having trouble performing or accessing because of the past limitation(s)?

3. How does the employee's past limitation(s) interfere with his/her ability to perform the job function(s) or access a benefit of employment?

QUESTIONS TO HELP DETERMINE EFFECTIVE ACCOMMODATION OPTIONS.

If an employee has a disability and needs an accommodation because of the disability, the employer must provide a reasonable accommodation, unless the accommodation poses an undue hardship. The following questions may help determine effective accommodations:

1. Do you have any suggestions regarding possible accommodations that are needed to improve job performance or to enable the employee to access a benefit of employment?
    a. Answer yes or no:
    b. If so, what are your suggestions?

2. How would your suggestions improve the employee's job performance or enable the employee to access a benefit of employment?

An individual with a record of a substantially limiting impairment may be entitled, absent undue hardship, to a reasonable accommodation if needed and related to the past disability. The following questions may help determine effective accommodations:

1. Do you have any suggestions regarding possible accommodations of the past disability that are needed to improve job performance or to enable the employee to access a benefit of employment?
    a. Answer yes or no:
    b. If so, what are they?

2. How would your suggestions improve the employee's job performance or enable the employee to access a benefit of employment?

3. Other Questions or Comments:

Health Care Provider Name:_____

Health Care Provider Signature:_____

Health Care Provider Address:_____

Health Care Provider Phone Number:_____

Date Signed:_____

Please return this form completed by the Health Care Provider to the ADA Coordinator at Minnesota State University Moorhead at the following fax number: 218-477-2123

If you experience difficulty faxing this form, please call the ADA Coordinator at the following phone number: 218-477-2157