I hereby authorize the following healthcare provider(s) and its physicians, employees, and agents to release or disclose to the North Carolina Central University Office of Human Resources – Equal Employment Opportunity Office only such medical information that is necessary to support this request for accommodation, including any specialty protected or listed records, such as those relating to psychological or psychiatric impairments, etc. This is *not* a request for my full medical record and/or history. Please list below the healthcare provider(s) that will be the agent for the release of information and/or the liaison for discussion with university representatives.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Healthcare Provider* |  | *Address* |  | *Phone Number* |
|  |  |  |  |  |
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I further authorize my healthcare provider to discuss with the designated North Carolina Central University Office of Human Resources Representative or Equal Employment Opportunity/AA Officer any confidential information with respect to my medical condition or treatment, either formally or informally. If requested the following should occur:

|  |  |  |
| --- | --- | --- |
| **Release Records to:** |  | North Carolina Central University  Office of Human Resources – Equal Employment Opportunity  1801 Fayetteville Street, 308 Hubbard-Totton Building  Durham, NC 27707 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Patients Name:** |  | **SSN: Last 4 Digits Only** |  | **Date of Birth:** |  |

|  |  |
| --- | --- |
| **Which Records?** | My medical information such as diagnosis and treatment records, hospital records, and other medical history if necessary to support the specific request for accommodation(s). |

|  |  |
| --- | --- |
| **Purpose of Disclosure:** | For use as relevant information in the consideration of a reasonable accommodation request with the university. |

I understand that I may revoke this authorization at any time prior to the expiration date or event, but that my revocations will not have any effect on actions taken by the above named provider(s) or its physicians, employers or agents before the healthcare provider(s) received my revocation. Should I desire to revoke this Authorization, I must send written notice to the healthcare provider(s) and North Carolina Central University.

I fully understand that if I do not sign this authorization, I may not be eligible to obtain a reasonable accommodation from North Carolina Central University as NCCU requires medical information/documentation to certify that I require and I am eligible for a reasonable accommodation.

I understand that my records may be subject to disclosure by the recipient, if required by state and federal law. I hereby release the healthcare provider(s), its physicians, employees and agents as custodians of my medical records from any and all liability covering all types of damage which may affect me, my heirs, my family or associates for compliance with this authorization and request for the release of information or compliance. The recipient of this release agrees not to release this information to any parties not affiliated with the Office of Human Resources or the Equal Employment Opportunity Office and that this Authorization does not limit the above-named healthcare provider(s) or its physicians, employees or agents the ability to use or disclose my information for treatment, payment, or healthcare operations, or as otherwise permitted by law.

I further understand and acknowledge that I am responsible for all costs associated with the provisions of the information described herein to North Carolina Central University, however, there is no cost for the University to process my accommodation request.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Patient or Authorized Representative’s Signature: | |  | | | |
| Relationship to Patient: |  | |  | Date: |  |

**NCCU EMPLOYEE:**

EEO/AA has received notification of your disability and/or need for a reasonable accommodation. To continue to the steps required to process your request, you will need to complete the attached Medical Records Release Authorization Form. The entire package (including the completed release form) is to be submitted to your physician or medical provider that’s treating you for your disability. Your medical provider is required to complete the Physician Certification Section of this document and to provide their qualifying medical provider credentials requested on the final page of this document. Once completed, your physician/medical provider should fax and mail the completed document directly to:

|  |
| --- |
| ***Delores Harris, Director of Employee Relations and Affirmative Action Officer*** |
| ***North Carolina Central University, P.O. Box 19714, Durham, NC 27707*** |
| ***(919) 530-6681 (O) (919) 530-7992 (F)*** [***dharr226@nccu.edu***](mailto:dharr226@nccu.edu) |

**ACCOMMODATION REQUEST – RELEVANT COVID19 INFORMATION**

Below you will find a listing of underlying conditions relative to COVID19. Please review and select all categories that best represents the nature of your medical condition and the COVID19 underlying conditions below.

I am 65 or older

I have asthma

I have a chronic kidney condition in which I am being treated with dialysis

I have a chronic lung condition

I am diabetic

I am immune-compromised (cancer, TB, etc.)

I have a hemoglobin disorder

I have a liver disease

I have a serious heart condition

I have severe obesity

Other (provide details in the following space)

|  |
| --- |
|  |

**PHYSICIAN CERTIFICATION**

1. **Patient Diagnosis:**

Please provide a narrative of the patient diagnosis(es) as it relates to this request for reasonable accommodation. Attach supporting documentation such as test results, e.g. an eye report with visual acuity and fields, audiology report, PT/OT evaluation, neuropsychological report, etc., and any additional sheets as necessary.

|  |
| --- |
| 1. **Primary Diagnosis:** |
|  |

|  |  |
| --- | --- |
| 1. **Date of Diagnosis:** | Click here to enter a date. |

|  |
| --- |
| 1. **History of Illness:** |
|  |

|  |
| --- |
| 1. **Describe the nature and severity of the impairment:** |
|  |

|  |
| --- |
| 1. **Is the condition intermittent or long term with chronic implications?** |
|  |

|  |
| --- |
| 1. **If temporary, what is the expected duration of this episode?** |
|  |

1. **Medication and/or Corrective Measures:**

Describes whether medication and/or corrective measures that may correct the impairment have been prescribed (e.g., medication lowers high blood pressure to acceptable level; or corrective lenses to improve vision to 20/20).

|  |
| --- |
|  |

1. **Substantial Functional Limitations:**

|  |
| --- |
| 1. **Diagnosis/Conditions:** |
|  |

|  |
| --- |
| 1. **Major Life Activities:** |
|  |

|  |
| --- |
| 1. **Substantial Functional Limitations:** |
|  |

1. **Recommended Accommodation:**

|  |
| --- |
| 1. **Please list your recommended accommodations (e.g., accessible buildings, alternative format materials such as large print, Braille, assistive technology, etc.) he/she may require to perform job functions safely and effectively.** |
|  |

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| --- |
| 1. **If the requested accommodation is time off work, how much leave is recommended?** |
|  |

|  |
| --- |
| 1. **Are there any activities or situations that should be avoided or that would present a significant risk of serious injury or death for the employee?** |
|  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Certifying Qualified Medical Provider/License Number:** | | | | | | | | | | | | | | | |
| **Provider Name:** | | | | |  | | | | | | | | | | |
| **Degree/Title:** | | |  | | | | | | | | | | | | |
| **Telephone Number:** | | | | | | |  | | **Fax Number:** | | | |  | | |
| **Business Address:** | | | | | |  | | | | | | | | | |
| **City:** |  | | | | | | | **State:** | |  | | **Zip:** | | |  |
| **Email Address:** | | | |  | | | | | | | | | | | |
| **Signature:** | |  | | | | | | | | | **Date:** | | | Click here to enter a date. | |

Thank you for your cooperation and promptness in providing this solicited information. The sensitive medical data shared will be handled in accordance with university policies and procedures, and as defined by state and federal laws. Your report will assist us in providing a most suitable and expeditious reasonable accommodation for the employee that is based upon your expert recommendations.