WAYNE STATE UNIVERSITY

Employee's Name: _____ **Banner ID:** _____

Patient's Name (if different fro employee): _____

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

I, _____ , hereby authorize _____
Employee Name Physician/Facility Name

to release to Wayne State University any requested medical information pertinent to my request for a reasonable accommodation. This authorization shall be valid for a period of 60 days from the date of execution or earlier if revoked by me in writing to Wayne State University. I hereby acknowledge that I have been informed of my right to receive a copy of this authorization request. I further acknowledge that I have been informed that if requested medical information is not released within 30 days from _____, my request for a reasonable accommodation may be denied.

Please provide the contact information for the Physician/Facility you are requesting to respond to your request for reasonable accommodation (please include suite #):

Name: _____
Address: _____
_____
_____
Phone: _____
Fax: _____
Email:

_____ _____
Employee Signature Date

Revised
10/25/17
TM