WAYNE STATE UNIVERSITY

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

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

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

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

to complete the Wayne State University ("WSU") disability and accommodation questionnaire, which is 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 WSU. 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 the requested questionnaire is not completed and returned to the Office of Equal Opportunity at WSU within 30 days from my signature date below, 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
02/6/23
TM