**University of Massachusetts Boston**

**Authorization for Release of Medical Information**

I hereby authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name of Health Care Provider

to disclose to the University of Massachusetts Boston Human Resources Department, information relative to my Request for Accommodation. I authorize my health care provider to provide Human Resources with information about my functional limitations related to my position, and their professional opinion, regarding potential accommodations that will assist me in performing the essential functions of my position. I understand that I must be able to perform the essential functions of my job with or without a reasonable accommodation.

Signature of Patient (Employee) Date

Printed Name