AUTHORIZATION TO RELEASE MEDICAL RECORDS/INFORMATION

TO: ______________________________
(Provider Name)

____
(Provider Address)

____

PATIENT: ______________________________

Date of Birth: _________________

The above-listed provider is hereby authorized to release and/or to discuss with appropriate representative(s) of the University of Notre Dame information (including records, reports, tests, histories, diagnosis, prognosis, etc.) obtained or made in connection with evaluation of my medical condition and directly related to my employment at Notre Dame and the potential for reasonable accommodations thereto. Please provide the requested information to:

Michael T. McCauslin
Risk Management and Safety Department
636 Grace Hall
Notre Dame, IN 46556
(574) 631-5037 phone
(574) 631-8794 fax

A copy of this authorization may be deemed valid by the health care provider.

I understand that I may revoke this authorization in writing and that it shall remain valid until revoked or upon the expiration of sixty (60) days, whichever occurs first.

______________________________ _________________
Patient Signature Date