ANGÉLICA INFANTE-GREEN
Commissioner

DOROTHY SMITH
Interim Superintendent

Providence Schools

Providence Public School District
Office of Human Resources
797 Westminster Street
Providence, RI 02903-4045
tel. 401.456.9100
fax 401.456.9284
www.providenceschools.org

AUTHORIZATON FOR RELEASE OF PROTECTED HEALTH INFORMATION

Print Patient Name:_____ Date of Birth_____

I authorize the use and/or disclosure of the above-named individual's health information as described in this authorization.

Person/Organization Releasing the information:
_____/_____

Address/Phone:
_____/_____

Release Information to: **Providence School Department**
Human Resources ADA
797 Westminster Street
Providence, RI 02903
Tel: 401-456-9100 x11173 **Fax: 401-456-9284**

The information to be used or disclosed:

Medical Treatment History

The purpose of the request is described below (each purpose must be listed):

Request for job accommodation under the Americans with Disabilities Act (ADA)

I understand that the information in my health record may relate to the results of diagnostic tests used to determine if I am infected by the human immunodeficiency virus (HIV) and/or treatment for alcohol or drug abuse. Unless I have indicated otherwise above, I specifically authorize the release of this information.

I understand that I have the right to revoke (cancel) this authorization at any time. I understand that to revoke this authorization, I must do so in writing and send my written revocation (cancellation) to the medical provider listed above and it will not apply to information that has already been released to this authorization.

Unless earlier revoked in writing, this authorization will expire at the conclusion of my treatment for injuries sustained on the above-mentioned date.

I understand that if I authorize the above-named medical provider to disclose information, the recipient of the information might disclose it to others and that any information disclosed by the above medical provider may no longer be protected by the federal rule on the privacy of medical records.

_____ _____
Signature of Patient or Authorized Representative Date

_____
Printed Name of Authorized Representative and relationship to patient

PROVIDENCE SCHOOL DEPARTMENT EMPLOYEES

Americans with Disability Act -- Accommodation Request Form

REFERRAL

DATE:_____

A. ORIGINATING DATA

NAME: _____ SOC. SECURITY #: _____

ADDRESS: _____

WORK LOCATION:_____ ASSIGNMENT: _____

TELEPHONE (Home): _____ (Work): _____

B. STATEMENT OF THE PRESENTING ISSUE (Be specific as to how your condition is affecting your work; state the accommodation being requested– attach additional information, if necessary):

C. SUPPORTING DATA: (attach all documents submitted by your physician, including authorization form and medical treatment history)

D. MEDICAL/HEALTH PROFESSIONAL DATA
Name of health provider: _____

Address: _____

Telephone: _____ Fax: _____

E. MEDICAL RELEASE

I hereby release to the Office of Human Resources at the Providence School department, all information concerning my medical condition, only as it relates to my request for an Accommodation. I understand that this form will be utilized only to assist the Providence School Department solely for that purpose.

Employee's Signature/Date: _____/