



**Alabama Agricultural and Mechanical University
Office of Human Resources**

Release of Medical Information Form (ADA)

Medical/Health Information

The undersigned hereby grants permission to Alabama A&M University, having its principal place of business at 4900 Meridian Street Normal, Alabama 35762, to discuss any and all medical/health related information with any medical practitioner, hospital, facility, or any other agency that has medical records or knowledge of the medical records of the undersigned for the purpose of evaluating the undersigned's request for a workplace accommodation under the Americans with Disabilities Act of 1990 (ADA) as amended.

Medical/Health Records

The undersigned hereby authorizes any medical practitioner, hospital, facility, or any other person or entity that has medical records or knowledge of the medical records of the undersigned to release such information upon request to Alabama A&M University, having its principal place of business at 4900 Meridian Street Normal, Alabama 35762, for purpose of evaluating the undersigned's request for a workplace accommodation under the Americans with Disabilities Act of 1990 (ADA), as amended.

Employee's (Patient) Printed Name: _____

Employee's (Patient) Signature: _____

Title/Position: _____

Employee's (Patient) Date of Birth: _____

Date: _____