State of New Jersey
[Facility's/Division's Name]
P.O. BOX [Insert]
[Insert facility/division address]

ADA AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

TO: ____
Name of Medical Provider

____
Address

______________________ ________________________ _______________
City State Zip Code

____
Medical Provider Phone Fax Number

RE: ______________________________ ______________________________
Name of Patient Birth Date or SSN

____
Address

______________________ ________________________ _______________
City State Zip Code

I hereby authorize ______________________________________ (Medical Provider) to disclose to the New Jersey Department of Human Services (DHS), or any person who is authorized by my employer to handle medical information for ADA purposes, any information concerning my physical or mental condition, that is necessary to determine whether I have a disability and to determine whether any accommodations can be made.

I also authorize DHS or any person who is authorized by my employer to handle medical information for ADA purposes, to speak to my treating physician or health care provider directly in regard to any questions he/she may have with respect to my condition that relates to the performance of the essential functions of my job and any accommodations that may be necessary.

I understand that the requested data is for the above-mentioned purposes, and that I may refuse to provide the requested medical information. However, I understand that if I refuse to provide the information, my employer may refuse to provide accommodation.

This authorization is valid for one year from the date indicated below or upon receipt of my signed written notice to withdraw my consent. A fax or photocopy is as valid as an original.

____ ____________________

Signature of Patient Date