University of Massachusetts Lowell
Authorization for Release of Medical Information

I hereby authorize_____
Name of Health Care Provider
to disclose to the University of Massachusetts Lowell, Equal Opportunity and Outreach (EOO) any information concerning my physical or mental condition in order to assess my ability to perform job related functions with or without a reasonable accommodation. I further authorize my health care provider to provide EOO a professional opinion regarding my medical condition and my ability to perform job related functions.

I also authorize representatives of EOO to speak directly to my health care provider concerning any questions with respect to my medical condition that relate to the performance of the essential functions of my job and any accommodations that may be necessary.

_____ _____
Signature of Patient Date

_____
Printed Name