Syracuse University
Human Resources

HEALTH CARE PROVIDER RELEASE FORM

Return to: HR Service Center
Skytop Office Building
Syracuse, NY 13244-1200
hrservice@syr.edu
Phone: 315.443.4042
Fax: 315.443.1063

I,_____("Employee"), give Syracuse University permission to

contact_____("Health Care Provider"). I understand the reason for this contact is so that my Health Care Provider may advise Syracuse University about my functional abilities and limitations in relation to my job functions. I understand that Syracuse will provide my Health Care Provider with specific information about my job position, including the essential functions and specific requirements of the job. I authorize my Health Care Provider to disclose my health information related to my functional abilities and limitations in relation to my job functions to Syracuse University as my employer, and that such health information may include, without limitation, HIV-related, alcohol or drug treatment, or mental health treatment information.

Date _____

Employee Signature_____

Witness Signature _____

Address of Health Care Provider: Provider Phone Number:

_____ _____

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