



Appendix B

**Grinnell College
Health Care Provider Release Form**

I, _____, give Grinnell College permission to contact my health care provider, _____.

(Please print your name in the first blank and print the name of your doctor/therapist/counselor)

I understand the reason for this contact is to advise Grinnell College about my functional abilities and limitations in relation to my job functions.

I understand that Grinnell College will provide my health care provider,

_____ with specific information about my job position, including the essential functions and specific requirements. All information obtained from employee medical examinations and inquires will be maintained and used in accordance with ADA confidentiality requirements.

Date: _____

Employee: _____

Witness: _____

Health Care Provider's name: _____

Health Care's practice/agency name: _____

Address of Healthcare Provider: _____

Phone number of Healthcare Provider: _____

Your Birth date (month/date/year): _____