COLUMBUS STATE
COMMUNITY COLLEGE

AUTHORIZATION FOR THE RELEASE OR USE OF PROTECTED HEALTH INFORMATION (PHI)

Employee or Applicant Information:

Name:_____

Mailing
Address:_____

Date of Birth: _____/_____/_____

I, _____, authorize _____
(Name of Employee/Applicant) (Name of Healthcare Provider)

to disclose protected health information (PHI) to Columbus State Community College – Office of Equity and Compliance.

Additional Provider Information:

Address:_____

Phone Number:_____ Fax Number:_____

The abovementioned protected health information is limited to that information which the College needs to know to assess my reasonable accommodation request.

The specific protected health information to be released is (choose all that apply):

_____ Confirmation that my medical condition is a disability under the Americans with Disabilities and its Amendments (ADA/ADAAA);

_____ Functional limitation(s) or work-related restrictions associated with the stated disability;

_____ Necessity of the requested reasonable accommodation;

_____ Clarification of medical information previously submitted to Columbus State;

_____ Recommendations regarding alternative accommodations.

By signing below, I understand that:

- Columbus State Community College will only request medical information that is directly related to the aforementioned.
- The information that is collected and discussed is to be treated with confidentiality. However, directly relevant information may be shared with others who need to know to address work restrictions and/or accommodations in order to make decisions or provide advice on matters relating to my request for reasonable accommodations. Disclosure of "Directly relevant information" means information will be shared on a need to know basis and will be limited to my functional limitations or restrictions that substantially impact my ability to perform essential job functions, and my healthcare provider's recommendations for accommodation(s); and will exclude diagnosis and treatment planning.
- This authorization shall expire on the completion date of the "event," one (1) year after the date of the signature below or until revoked by me in writing, whichever shall come first. "Event" may be defined as the reason the signed authorization is needed.
- I have the right to revoke this authorization at any time by providing written notice to the Office of Equity and Compliance.
- A revocation of this authorization will not affect any proper disclosure of information by Columbus State Community College done in reliance on the authorization prior to the receipt of the written notice of revocation.

Signature of Individual or Authorized Representative	**Print Name of Individual**	**Date**
Representative's legal authority to individual (parent to a minor, Power of Attorney, legal guardian)	**Print Name of Authorized Representative**	

Photocopy must be given to individual or individual's authorized representative.