HARVARD SCHOOL OF PUBLIC HEALTH

GENERAL AUTHORIZATION TO USE AND DISCLOSE MEDICAL INFORMATION

FAX THIS FORM ALONG WITH THE MEDICAL HISTORY QUESTIONNAIRE TO: CAROL DENNEHY/ FAX NUMBER: 978-247-6081

Individual's Name: _____
Last **First** **Middle**

Home Address: _____

Home Telephone: _____ Harvard ID Number: _____

By signing my name, I authorize the following use and disclosure of my medical information:

1. I authorize personnel retained by Harvard University's Disability Claims Unit ("DCU"), including but not limited to its contract nurse(s), to review the Harvard health questionnaire that I have completed (and any subsequent annual health status questionnaire that I may complete) for purposes of assessing:

(a) my ability to perform the essential functions of a job at Harvard University, with or without reasonable accommodation and without posing a direct threat to the health or safety of myself or others; or, if I am not a Harvard employee, my ability to effectively provide services at, or have access to, the facilities of the Harvard school of Public Health without posing a direct threat to the health or safety of myself or others,

(b) what, if any, reasonable accommodations are needed; and/or

(c) the necessary or appropriate follow-up (including, but not limited to evaluation and clearance by my personal physician, and recommendations for tests, vaccinations or immunizations).

2. In the event that necessary or appropriate follow-up is identified, I also authorize Deedee Gaudette, Director of Disability Claims Unit, or her designee to disclose the medical information described in paragraph 1 to a physician identified by me, and to communicate with that physician concerning my fitness to return to the Harvard School of Public Health.

I further understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason, except, however, I further recognize that such refusal to sign this Authorization or a revocation of it may prevent Harvard University from providing me with appropriate workplace accommodations and/or with access to Harvard School of Public Health facilities. I also understand that if I refuse to sign this Authorization in connection with a pre-placement evaluation, that Harvard University may rescind my offer of employment. Any revocation will be effective immediately upon Harvard's receipt of my written notice, except that the revocation will not have any effect on any action taken by Harvard in reliance on this Authorization before it received my written notice of revocation. Any revocation should be directed to the attention of Deedee Gaudette, Director of Disability Claims Unit, Harvard University, 1414 Massachusetts Avenue, Cambridge, MA 02138.

A copy of this Authorization shall be equally effective as the original.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my medical information. By my signature below, I hereby, knowingly and voluntarily, authorize the use and disclosure of my medical information in the manner described above.

_____ _____
Signature of Individual **Date**

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