University of New Hampshire

HEALTHCARE PROVIDER RELEASE FORM

I, _______________________________________ give the University of New Hampshire permission
(Your Name)

to contact ____.
(Healthcare Provider's Name)

I understand the reason for this contact is to advise the University of New Hampshire about my functional abilities and limitations in relation to my job functions. I understand that the University of New Hampshire will provide ___________________________________with specific information about
(Healthcare Provider's Name)

my job position, including the essential functions and specific requirements. All information obtained from medical examinations and inquiries will be maintained and used in accordance with the Americans with Disabilities Act of 1990 (ADA) confidentiality requirements.

Date: ____________________________

Your signature: _______________________________ Your Birth Date:_________________________

Healthcare Provider Name, Title and Address:

Name & Title: ____

Address: ____

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Phone: ____________________ Fax: ______________________

Once your form has been filled out, save as a PDF and include your first and last name in the title and a description of the form(s) you are submitting, You can attach more than one document to the email. For example: **LASTNAME_FIRSTNAME – Healthcare Provider Release**

When you are ready to submit your documents, click here. Attach your document(s) to the UNH Box email address populated in your selected email application and click Send. Your attachments will be sent directly to a secure UNH folder in Box. *Please note that only the attachments will be saved in the Submission Inbox and any message written in the body of the email will not be received. You will receive a confirmation email receipt delivered to the email address you submitted your forms from.*

This form is available in alternate format upon request.
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