# University of Massachusetts Lowell
# Authorization for Release of Medical Information

I hereby authorize_____
Name of Health Care Provider
to disclose to the University of Massachusetts Lowell, Equal Opportunity and Outreach (EOO) information relevant to my request for reasonable accommodation. I authorize my health care provider to provide EOO information about my functional limitations related to my position, and their professional opinion regarding potential accommodations that will assist me in performing the essential functions of my position. I understand that I must be able to perform the essential functions of my job with or without a reasonable accommodation.

_____ _____
Signature of Patient Date

_____
Printed Name