COLUMBIA UNIVERSITY HUMAN RESOURCES

Disability Information Release Form

Instructions

Please submit form to: Leave Management Office 615 West 131st Street, MC 8703 Studebaker 4th Floor New York, NY 10027; **fax:** (212) 851-7069. **Questions:** (212) 851-0698 or leavemanagement@columbia.edu

Physician/Clinician #1

I, _____ (Employee's name), hereby give permission for

_____ (Physician/Clinician) to release any pertinent

information on _____ (Employee's name) to the Columbia University Office of Disability Services. I understand that any information received will be kept confidential and will be released only to the extent necessary to obtain accommodations.

Employee Signature:_____ Date (mm/dd/yyyy):____/____/_____

Witness Signature (Optional) : _____ Date (mm/dd/yyyy):____/____/_____

Physician/Clinician #2

I, _____ (Employee's name), hereby give permission for

_____ (Physician/Clinician) to release any pertinent

information on _____ (Employee's name) to the Columbia University Office of Disability Services. I understand that any information received will be kept confidential and will be released only to the extent necessary to obtain accommodations.

Employee Signature:_____ Date (mm/dd/yyyy):____/____/_____

Witness Signature (Optional):_____ Date (mm/dd/yyyy):____/____/_____

Physician/Clinician #3

I, _____ (Employee's name), hereby give permission for

_____ (Physician/Clinician) to release any pertinent

information on _____ (Employee's name) to the Columbia University Office of Disability Services. I understand that any information received will be kept confidential and will be released only to the extent necessary to obtain accommodations.

Employee Signature:_____ Date (mm/dd/yyyy):____/____/_____

Witness Signature (Optional):_____ Date (mm/dd/yyyy):____/____/_____