EASTERN MICHIGAN UNIVERSITY

Release of Medical Information Form

INSTRUCTIONS FOR HEALTH CARE PROVIDER

Our employee has reported an illness or injury to our office about which we require additional information. The employee's signature below authorizes you to provide to Eastern Michigan University information regarding his/her general health, including information regarding mental, emotional or drug abuse treatment. This authorization is provided for your records.

Please be specific and objective since this information may affect this person's employment, compensation, or benefits. Confidential information may be reviewed by the University's human resources personnel. Please include sufficient details as to this person's health or ability to work. Complete information should minimize the need for further correspondence or telephone calls.

A copy of this form shall be as valid as the original.

INSTRUCTIONS FOR STAFF MEMBER

Please complete and sign the statement below. Take or mail this form to your medical care provider.

Authorization for Release of Medical Information.
I authorize you to provide to Eastern Michigan University information regarding your findings as to the present condition of my health as it relates to my ability to work. This release may be revoked at any time and will be valid no longer than is reasonably necessary to accomplish the purpose for which it is given.

_____ _____

Name of Staff Member (please print) Date Signed

_____ _____

Signature of Staff Member Social Security Number