RESIDENT NAME: ________________________________

Section A – Completed by Resident / Applicant for Housing

Authorization to Release Medical Information and/or Medical Records

I, ________________________________, hereby authorize ________________________________, Name of licensed Physician/ Treating Provider (please print), to release medical information and/or records* to the UC Santa Barbara Disability Services Manager for the purpose of evaluation of Housing accommodations.

I fully understand the nature of the records, their contents, the consequences and implication of their release. I hereby release the source of these records from any liability arising from their release. I authorize the parties below to talk by telephone about my referral, diagnoses, treatment and similar topics relevant to the above listed purposes for this release of records.

I understand that I may revoke this consent at any time within 90 days except to the extent that action based on this consent has been taken. This consent will expire automatically after 90 days from the date on which it is signed, or upon the fulfillment of the above purpose.

______________________________  ________________________________
Resident Signature              Date

Section B – Completed by Physician / Treating Provider

Information in this Section is CONFIDENTIAL, therefore, will NOT be shared with the Housing Office

Under the Americans with Disabilities Act (ADA) and the Fair Employment and Housing Act (FEHA), a disability is a physical or mental impairment that (substantially) limits one or more major life function(s).

Questions to help determine whether an employee has a disability which limits a major life activity:

1. Does the Resident have a disability/impairment?  Yes ☐   No ☐
   If yes, what is the disability*?

2. Is the disability temporary?  Yes ☐   No ☐
   If yes, how long will the disability last?

Additional Comments: ________________________________

*The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. ‘Genetic information,’ as defined by GINA, includes an individual’s family medical history, the results of an individual’s or family member’s genetic tests, the fact that an individual or an individual’s family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

______________________________  ________________________________
Physician / Treating Provider’s Signature              Date

______________________________  ________________________________
Print Name              Practice Specialty

______________________________  ________________________________
Address or Stamp              Phone Number

FAX TO:  Elizabeth Delo, Disability Services Manager, UC Santa Barbara
FAX (805) 893-8269  Phone (805) 893-8571
Medical Response for Faculty/Staff Housing Accommodations

RESIDENT NAME: ________________________________

Section C – Completed by Physician / Treating Provider

Please do NOT share diagnoses in this section – Information in this section regarding functional limitations and restrictions WILL be shared with the Housing Office.

An individual with a disability is entitled to reasonable accommodations in Housing when needed. The following questions may help determine whether an accommodation needs to be explored because of the disability.

Questions to help determine whether a Housing accommodation is needed:

1. What are the Resident’s specific restrictions and/or functional limitations?

2. How long are the restrictions and/or functional limitations expected to be in place?
   Anticipated end date: ____________________________

3. What function(s) is the Resident having trouble performing because of the limitation(s)?

4. Do you have any suggestions as to possible Housing accommodation(s)?

If an Emotional Support Animal is being requested, please complete Page 3.

FAX TO: Elizabeth Delo, Disability Services Manager, UC Santa Barbara
FAX (805) 893-8269 Phone (805) 893-8571
Section C – Completed by Physician / Treating Provider (continued)

If an Emotional Support Animal is requested, please complete this page in addition to pages 1-2.

5. Please describe in detail how the Emotional Support Animal alleviates or mitigates the Resident's symptoms/functional limitations:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Additional comments:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________