UNIVERSITY OF
SOUTH DAKOTA

Release of Information
Faculty/Staff

Name: _____

Social Security Number: _____

Date of Birth: _____

Physician or Facility:

Name: _____

Address: _____

_____

Phone Number: _____

Fax Number: _____

I, _____, hereby grant the above mentioned physician/facility release information to or exchange information with Human Resources at The University of South Dakota in regards to my request for workplace accommodations. I understand that I may revoke this consent by written or oral communications any time except to the extent that action based on this consent has already been taken. I agree that Human Resources may use electronic means to transfer information. I certify that this form has been fully explained to me and that I understand its contents.

Signed: _____ Dated:_____

Witness: _____ Dated:_____

Human Resources, Slagle 206 ▪ 414 East Clark Street ▪ Vermillion, SD 57069-2390
Phone: 605-677-5671 ▪ Fax: 605-658-3660