SAMPLE- **TO OBTAIN AN ELECTRONIC TEMPLATE CONTACT BEEO:**

**Letter to Health Care Provider—HIPAA Consent**

Dr. [Insert Health Care Provider],

[Insert Employee Name], an employee of the Pennsylvania [Insert Agency Name] has identified you as [his/her] health care provider. [Insert Employee Name] has informed the [Insert Agency Name] that [he/she] has a medical condition that [he/she] identifies as a [Insert Condition Name] and has requested an accommodation under relevant commonwealth human resources policies which are derived from pertinent provisions of the Americans with Disabilities Act (ADA). [Insert Employee Name] has executed a HIPAA form (attached) authorizing you to disclose information regarding [his/her] medical condition.

Please provide detailed answers to the questions in the attached Health Care Provider Questionnaire. To assist you in completing this document, I am providing “Additional Information and Definitions”. Please be advised that answers should reflect the impact of the symptoms without regard to the ameliorative effects of mitigating measures such as those listed in the “Additional Information and Definitions”.  However, the ameliorative effects of ordinary eyeglasses or contact lenses should be considered in determining whether the impairment substantially limits a major life activity.  The information you provide will be considered confidential and used only to evaluate [Insert Employee Name] request for accommodation.

Thank you for your cooperation and assistance in this matter. Please return the completed form in the enclosed pre-addressed stamped envelope on or before [Insert Date]. If you would like to discuss this matter please feel free to call me at (717) [Insert Telephone Number].

Sincerely,

[Insert Name]

[Insert Contact Information]

cc: [Insert Employee Name]