

**Office of EEO/AA  
Services**

Ginter House, Room 114  
901 West Franklin Street  
P.O. Box 843022  
Richmond, Virginia 23284-3022

804 828-1347  
Fax: 804 828-7201  
TDD: 804 828-1420

**RELEASE FORM  
PERMISSION TO CONTACT PHYSICIAN**

Please read and complete (Please print legibly)

I give permission to:

**Name:** \_\_\_\_\_

**Position/Title:** \_\_\_\_\_

**Department:** \_\_\_\_\_

To contact my physician to discuss my medical condition as it relates to my employment at Virginia Commonwealth University. My physician's name, address, and telephone number are as follows:

**Name:** \_\_\_\_\_

**Type of Physician:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_

**Employee's Name:** \_\_\_\_\_

**Signature/Date:** \_\_\_\_\_