To: University of Virginia Students and Alumni

Subject: Release of Medical Records

1. You must complete a Student Health "Consent for the Release of Medical Information Form." You can obtain one of these forms at Student Health.

2. Occasionally Student Health receives a signed statement from a student stating that he wishes his medical information to be released to his parents. Student Health requires students to use a standard consent form that complies with state and federal laws for release of medical information. If you complete the Student Health Consent form and return it to us, we will be happy to respond to requests from you or your parents to provide them the applicable medical information contained in Student Health records at the time the request is made.

3. Options:
   a. Copy of Pre-Entrance Immunization Health Form (including any immunizations on file). **No Cost**
   b. Copies of Medical Records are free of charge if a Student Health provider refers a student to an outside health care provider. If a student requests copies of their Medical Record for other reasons, the cost is $.50 per page for the first 50 pages then $.25 per page thereafter.

4. You may review your records by obtaining a copy as noted above; or as a full time enrolled student, you can review your records by making an appointment with a Student Health Care Provider.

5. Student Health will respond to all routine requests for medical information within ***TEN (10) WORKING DAYS*** after receiving a completed "Consent for the Release of Medical Information Form."

6. Student Health saves medical records for ten (10) years after the date of your last visit to Student Health.

7. If you have never been seen by a Student Health care provider while enrolled in UVa, your immunization records are kept for two (2) years after your departure from this university.

UNIVERSITY OF VIRGINIA
DEPARTMENT OF STUDENT HEALTH
P.O.BOX 800760 Telephone: 434-924-1525
Charlottesville, VA 22908-0760 FAX : 434-982-4262

Processed:_____ Date:_____
Office Use Only

CONSENT FOR THE RELEASE OF MEDICAL INFORMATION

Instructions: The patient must complete this form in its entirety in order for any healthcare facility to release medical information. The patient must be specific as to the nature of the information he/she would like released and the purpose for which it is requested.

I hereby authorize_____
(Name of individual or agency)

_____
(Address)

to release my medical records as described below: (check appropriate box(s))
□ General Medicine Clinic Notes & Labs □ Gynecology Clinic Notes & Labs □ CAPS Clinic Notes
□ LNEC Confirmation of Disability Accommodations □ Immunization Record
□ Other (must specify) _____

accumulated during the period beginning _____ and ending _____
(mo/day/year) (mo/day/year)

To_____
(Name of individual or agency)

_____
(Address)

❒ fax ❒ telephone_____ for the purpose of_____

This information is for use by the recipient named above only, and may not be disclosed to any other individual or agency without the patient's consent or as otherwise provided by law. This authorization is subject to revocation at any time except to the extent the healthcare facility has already taken action in reliance on it.

I understand that the information in my medical records may include information related to sexually transmitted disease, AIDS/HIV testing or diagnosis, mental health services, or drug/alcohol abuse diagnosis or treatment, and I consent to its release unless indicated in the following instructions:

_____.

I understand that Student Health will not withhold health care if I do not sign this consent, but that disclosure of private information to an outside entity such as a future employer or consulting physician will not be made without your consent. A copy of this consent and a notation concerning the persons or agencies to which disclosure was made will be included in my medical records. I understand that health information disclosed under this consent might be redisclosed by a recipient and no longer be protected by privacy laws.

Patient's Signature _____ Patient's Date of Birth _____

Printed Name _____ I.D..# _____

Address _____

Telephone Number _____

Date: _____ This authorization will expire in one year.

Revised September 17, 2007 JAM