UNIVERSITY of VIRGINIA | Department of Student Health and Wellness

CONSENT FOR RELEASE OF MEDICAL INFORMATION

Patient Label

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 they would like released and the purpose for which it is requested. **Please print using black ink.**

I (printed name)_____(date of birth)_____ (email address)_____

(address)_____(phone number)_____

hereby authorize (Name of Person or Agency)_____

- ☐ **to discuss /exchange medical information relevant to my care**
- ☐ **to release medical records as described below**

With/To: (Name of Person or Agency)_____

Address:_____

Telephone #_____ Fax #_____

(Records cannot be emailed)

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

Type of records/information to be released:

☐ Medical Services Notes & Labs ☐ Nutrition Notes
☐ Counseling and Psychological Notes ☐ Wahoo Well Notes
☐ Immunization Record
☐ SDAC Confirmation of Disability Accommodations
☐ Other (must specify):_____

Reason for this request:

☐ Coordination of Care outside of Student Health and Wellness
☐ Graduating/Terminating Care with Student Health and Wellness
☐ Insurance Claim
☐ Other: _____

This information is for use by the parties 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 and Wellness will not withhold health care if I do not sign this consent, but that exchange of private information with an outside entity such as a future employer or consulting physician will not be made without my consent. A copy of this consent and annotation concerning the persons or agencies with which information was exchanged will be included in my medical records. I understand that health information exchanged under this consent might be redisclosed by a recipient and no longer be protected by privacy laws. I *understand there is a handling fee not to exceed $10.00 and a fee of $.50 per page for pages 1-50, $.25 per page for pages 51+ Fees are waived when copies are requested for other health care provider's facilities/agencies for continuity of care.*

PATIENT OR LEGAL REPRESENTATIVE SIGNATURE:
By signing below, I state that I am 18 years of age or older and authorize the release of my information to the parties identified above. I have read or have had explained to me the contents of this form. I have had a chance to ask questions and all my questions have been answered. This authorization will expire in one year.

_____	_____	_____
Name (print) of Patient or Legal Representative	Signature	Date
_____	_____	_____
Name (print) of Staff Member Receiving Request	Signature	Date

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FOR OFFICE USE ONLY
Disposition of Medical Records:
☐ Faxed ☐ Mailed ☐ Picked Up

Staff Signature:_____ Date:_____

Staff Name (print):_____