UVA | Department of Student Health and Wellness

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

**I hereby authorize:** _____
(name of Provider(s) or Department(s))

☐ **to exchange/receive/discuss medical information relevant to my care:** ***(specify in "other" below)***
☐ **to release medical records as described below to:** ***(check appropriate box(s))***

☐ Medical Services Notes & Labs
☐ Health Promotion Notes
☐ CAPS Clinic Notes (Counseling and Psychological)
☐ SDAC Records Confirmation of Disability Accommodations
☐ Immunization Record
☐ Other (must specify) _____

for the period beginning_____and ending _____
(mo/day/year) (mo/day/year)

☐ **Between** ☐**From** ☐ **To**: _____
(Name of individual or agency)

_____
(Address)

Telephone# _____ for the purpose of _____
Fax#_____ *(Records cannot be emailed)*

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 consentand 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's Signature_____Patient's Date of Birth _____

Printed Name_____I.D.#_____

Address_____

Telephone Number_____Email Address _____

Date:_____This authorization will expire in one year. **Received by:** _____
**SHW Staff Signature**

Revised May 2022