UVA-WorkMed

Authorization for Release of Occupational Health Records

Date:_______________

Name:____ Employee ID: _______________

Email Address: ____________________________________ Date of Birth: ________________

I authorize UVA-WorkMed to release health information as described below:

1a. To myself when requested ☐

1b. To my employer for personnel purposes at my request
Employer: University of Virginia ☐ Other ☐ Please specify: _______________________

Dept./Division:_______________________

2. The information to be released is the entire UVA-WorkMed medical **record, including records of employer-requested occupational health services**, such as evaluations, immunizations, and/or testing services, and any other provider services records that are contained in the UVA-WorkMed medical record.

I understand that I have a right to revoke this authorization at any time. My revocation becomes effective when delivered in writing to UVA-WorkMed. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization will expire in ten (10) years from the date signed, unless an expiration date, event or condition is specified as follows:
____

I understand that the information released to the above individual or organization may be redisclosed and no longer be protected to the same extent as such health information was protected by law while solely in UVA-WorkMed's possession.

I understand that UVA-WorkMed may condition its providing of the above described health evaluation or treatment on my signing of this authorization, because the evaluation or treatment is being provided specifically for its results to be released under this authorization.

Signature of Patient: ____

Form updated: 7/9/2016

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