CONSENT & REQUEST TO RELEASE MEDICAL INFORMATION TO UHWS

Patient Name: _____ Class Year_____

Date of Birth_____ SSN_____ CNU ID_____

Your Rights to Medical Information Confidentiality
Under Virginia law, if you are 18 or older, you have the right to confidentiality regarding your visits to University Health & Wellness Services (UHWS). In order to release any information including the date or nature of your visit, you must provide written and signed consent with specific directions about what information you are consenting to be released. Without written consent, UHWS cannot release or discuss any information relating to your visit with anyone including your parents, guardians, spouse, faculty, staff, coaches and other medical professionals.

_____
Name of person, agency or provider

Street Address: _____

_____
City State Zip Code

Phone: _____ Fax: _____

May release

_____ My entire medical record
_____ Specific information regarding: _____

_____

And fax or mail copies to:

Health & Wellness Services
Christopher Newport University
1 University Place
Newport News, VA 23606-2998

Phone: (757) 594-7661
Fax: (757) 594-8853

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As the person signing this consent, I understand that I am giving my permission to the above named health care facility to disclose my confidential health care records.
In addition I understand that I have the right to revoke this authorization at any time, and that revocation is not effective until a signed, written revocation is received in your office. I understand that a copy of this authorization will be kept in my health record. I also understand that the information disclosed under this authorization might be redisclosed by a recipient and may, as a result of this disclosure, no longer be protected to the same extent as this information was protected by law while solely in your possession.

This consent expires on _____
Date

Signature: _____ _____
Date