UVA Occupational Health & Wellness

Authorization for Release of Information

Name: _____ Date of Birth: _____

I authorize UVA Employee Health/WorkMed to release my Employee Health/WorkMed information as described below:

The information to be released is the entire UVA Employee Health/WorkMed medical record of employer-requested occupational health services, including evaluation, immunization, and/or testing services.

I understand that I have a right to revoke this authorization at any time. My revocation becomes effective when delivered in writing to UVA Employee Health/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 may be re-disclosed and no longer be protected to the same extent as such health information was protected by law while solely in UVA Employee Health/WorkMed possession.

I understand that UVA Employee Health/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.

When releasing my records, please send my records to the following email:

_____

_____

Signature Date