



Authorization for Release of Information
UNIVERSITY OF VIRGINIA (207) EMPLOYEES

Date: _____

Name: _____ SSN: _____-_____-_____

(Provision of your Social Security Number is voluntary; it will be used for purposes of identification.)

I authorize UVA-WorkMed to release health information to my employer for personnel purposes at my request, as described below. I understand that no authorization is necessary to permit UVA-WorkMed to share medical information related to workers' compensation and certain other services required by law.

1. Please release my information to my Department/Division and/or University Human Resources.

Department: _____

2. The type and amount of information to be released is as follows:

Check requested services:

Work Related Assessment

Injury

Illness

Infectious Disease Exposure

Blood, Body Fluid

Disease

Physical Exam

Type: _____

Fitness for Duty/Limited

Illness

Injury

Animal Protocol Assessment

Fitness for Duty/Comprehensive

Environmental Exposure Assessment

Type: _____

Immunization

Type: _____

Medical Surveillance

Type: _____

Labwork

Type: _____

New Employee Health Assessment

Annual Assessment

Ergonomics Evaluation

PPD Assessment

Other: _____

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 six (6) months 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 not provide the requested health evaluation or treatment if I do not sign this authorization, because the evaluation or treatment is being provided specifically for the University to receive information about my condition.

Signature of Patient: _____

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