TO: Health Professions Students/ Radiologic Technology

FROM: Philip Diller, M.D.
Interim Director, University Health Services

RE: Medical Requirements for Enrollment
(UC Health – Student Health)

Welcome to the University of Cincinnati! University Health Services provides comprehensive health services for students at the University. In addition, we collect, review and assist health professions students with documenting the health-related requirements of their program.

The Immunization History must be completed by your personal physician (not a relative). Please note the requirements and recommendations regarding immunization and health insurance.

Also provided is the Family Educational Rights and Privacy Act (FERPA) Notice. Read the information and return the signed acknowledgement along with your immunization documentation, statement of comprehension and UHS registration form.

In order for your registration to be complete, you must schedule an appointment to be seen at UC Health – Student Health. Location: Holmes Building, 4th floor (located at the corner of Eden Avenue and Albert B. Sabin Way) Call 513-584-4457 to make a nurse appointment. This visit will allow us to review your history. Please feel free to contact our office if you have any questions.

Fee Information

(1) Students will be charged a $20.00 fee for the immunization registration appointment at the time of your visit. If your immunizations are complete (including the entire Hepatitis B series) and documented by your physician as requested by the deadline listed on the requirements page of this packet, you will be marked as complete and not charged any tracking fees.

(2) Students working through the initial Hepatitis B series and/or titer at the time of the deadline will be charged a $50.00 tracking fee. The registration fee and tracking fee due at the time of your review appointment may be charged to your UC student account if desired.

(3) For those who are not considered complete, there are additional $50.00 tracking fees at specific deadlines if you fail to progress. This fee will be generated from our billing department.

4/2015
PD:It
**REQUIREMENTS**

**IMMUNIZATION HISTORY— DOCUMENTATION OF IMMUNIZATION MUST BE SIGNED BY YOUR PERSONAL PHYSICIAN/CLINICIAN (not a relative). FAILURE TO COMPLY MAY RESULT IN SUSPENSION FROM CLASSES.** (Notes from parents and records from baby books are not acceptable.)

*It is highly recommended to send in items early and to schedule your review appointment in advance of the deadline.*

<table>
<thead>
<tr>
<th>Registration &amp; Tracking Fee</th>
<th>REQUIRED</th>
<th>Tell Me More About This</th>
</tr>
</thead>
<tbody>
<tr>
<td>A $20.00 fee will be due at time of review.</td>
<td>All up to date documentation is required to be on file with University Health Services before you can schedule an appointment for your review. You must schedule an appointment with the medical staff located at the UHS Medical Campus location, 4th floor, Holmes building to review your documentation and test for color blindness by calling 513-584-4457. Review must be complete: <em>Before July 31, 2015</em></td>
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<tr>
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<td>Required Review</td>
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<td></td>
<td>MMR</td>
<td>We require documentation of serologic immunity OR 2 documented MMR (Measles, Mumps, Rubella) vaccines (one since 1980).</td>
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<tr>
<td></td>
<td>MMR booster if needed</td>
<td>If you do not have documentation of 2 MMR Vaccines, (once since 1980) and/or the MMR titer is negative, a booster will be required.</td>
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<tr>
<td></td>
<td>Established Hepatitis B documentation</td>
<td>Health care workers are at high risk for Hepatitis B infection. UC Blue Ash requires that you receive a complete Hepatitis B vaccination series and have a Hepatitis B surface antibody titer drawn 4-8 weeks after your third immunization to show serologic immunity.</td>
</tr>
<tr>
<td></td>
<td>For students working through the Hepatitis B series</td>
<td>Students working through the initial series and including titer will be expected to follow the recommended dosing schedule, upon completion of the 3rd vaccine the HBsAb will be due 4 weeks later. A negative titer report will result in additional vaccines and titers, therefore the Hepatitis B series and documented proof of serology may take 7-14 months to complete. All students in this category cannot be expected to complete all requirements by November 1, 2015 and will automatically be charged the tracking $50.00 fee.</td>
</tr>
<tr>
<td></td>
<td>Chickenpox</td>
<td>All students will be required to have either a positive V2V (Varicella IGG) titer OR provide documentation of two immunization doses. Any susceptible students will be required to receive 2 doses of V2V vaccine</td>
</tr>
<tr>
<td></td>
<td>VZV Vaccine if needed</td>
<td>No vaccine history or negative titer. Any susceptible students will be required to receive 2 doses of V2V vaccine.</td>
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<tr>
<td></td>
<td>Tdap</td>
<td>1 adult Tdap vaccine. (Tetanus, Diphtheria and Pertussis)</td>
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<tr>
<td></td>
<td>BASELINE AND ANNUAL TB TESTING IS REQUIRED</td>
<td>Those individuals who have not had TB testing in the past 18 months will be required to have “2-step” baseline testing 7-21 days apart. MM induction must be included with documentation. YOU WILL NOT BE PERMITTED TO PARTICIPATE IN CLINICAL ROTATIONS IF YOU ARE NOT IN COMPLIANCE WITH THIS REQUIREMENT</td>
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<tr>
<td></td>
<td>(For students just with past history of positive PPD) +PPD Documentation</td>
<td>If PPD skin test is positive: DOCUMENTATION IS REQUIRED. A chest x-ray report within 12 months is required for PPD positive persons or a negative Interferon Gamma Release Assay (IGRA). X-rays are available at University Health Services. Annual PPD testing thereafter due 1 year from previous record on file. YOU WILL NOT BE PERMITTED TO PARTICIPATE IN CLINICAL ROTATIONS IF YOU ARE NOT IN COMPLIANCE WITH THIS REQUIREMENT.</td>
</tr>
<tr>
<td></td>
<td>FERPA</td>
<td>All of your medical documents will be considered confidential material and will only be released as described in the enclosed FERPA form. Please return the signed portion of the FERPA form and return it with your physician signed immunization form.</td>
</tr>
<tr>
<td></td>
<td>Statement of Comprehension</td>
<td>This statement will be kept on file. Please be sure to completely read and understand all of the requirements. Your signature indicates that you fully understand your responsibility and are aware of consequences regarding noncompliance.</td>
</tr>
</tbody>
</table>

**An additional $50.00 fee will be placed on your student account for those who are not complete with the requirements in this section by November 1, 2015.**

| All noncompliant students | Any student who fails to submit requested documentation by designated deadlines may be subject to this fee. It is the student’s responsibility to respond to e-mails and submit documentation as well as confirm any faxed documents in regards to their arrival to University Health Services. This fee will be sent directly to your student account. If you are noncompliant, your program will be notified. |
| **2015 Flu Vaccine** | **2015 INFLUENZA VACCINE AND ANNUAL REQUIRED.** Documentation of 2015 Flu shot will be required. The deadline will be made by UC Blue Ash as soon as the vaccine becomes available. Flu shot is required annually. |

**An additional $50.00 fee will be placed on your student account for those who are not complete with the requirements in this section by May 1, 2016.**

| For students requiring Hepatitis B boosters | For those students who will be repeating the Hepatitis series, your recommended dosing schedule may extend beyond the May 1, 2016 deadline. Adhering to your recommended dosing schedule will not result in the additional fee associated with the May 1, 2016 deadline; however please note that if do not adhere to the dosing schedule this additional fee will be sent to billing. It is vital that you communicate with the University Health Services Holmes Clinic if there are any circumstances creating a conflict. |
| All noncompliant students | Any student who fails to submit requested documentation by designated deadlines may be subject to this fee. It is the student’s responsibility to respond to e-mails and submit documentation as well as confirm any faxed documents in regards to their arrival to University Health Services. This fee will be sent directly to your student account. If you are noncompliant, your program will be notified. |

The above requirements apply unless medically contraindicated (must provide physician documentation). Additional testing, evaluation and documentation may be required in individual cases.

**HEALTH INSURANCE REQUIREMENT**

**HEALTH INSURANCE:** The University of Cincinnati requires that you be insured for health care either under the available UC Student Health Insurance Plan or a comparable policy of your own choice. As a full-time student you will be automatically enrolled in and billed for the insurance plan. If you have equal or better insurance and would like to waive the coverage, you must waive on-line by September 7, 2015. (www.onestop.uc.edu/) The coverage’s required for you to waive the UC Student Health Insurance Plan can be found at (http://www.uc.edu/uhs by choosing the Student Health Insurance at the top of the left of the page. Failure to waive by the deadline will result in a non-refundable charge to your tuition account. Please call the Student Health Insurance Office at (513) 556-6868 if you have any questions.
The image contains a document titled "UNIVERSITY HEALTH SERVICES IMMUNIZATION HISTORY (To be completed by a physician)

Patient Name: ___________________________ DOB (mm/dd/yyyy): ___________________________

Student ID: ___________________________ e-mail address required - please write legibly:

**UC BLUE ASH – RADIOLOGIC TECHNOLOGY**

**DPT/ Tdap**
- 5 childhood doses and booster every 10 years
- Dates of primary series:
  - #1
  - #2
  - #3
  - #4
  - #5

1 Adult Tdap dose given: Date ___________________________

**MINIMUM REQUIREMENT**
- Documentation of a Tdap vaccine.

**Polio**
- 3 childhood doses and booster: *Booster date required:
- Dates of primary series:
  - #1
  - #2
  - #3
  - Booster ___________________________

**MINIMUM REQUIREMENT**
- *Booster date required, however booster not needed if 3rd dose given after age 4

**MMR**
- MMR #1 ___________________________
- MMR #2: ___________________________

If titer is negative, booster and Re-titer: 4 weeks after booster

**MINIMUM REQUIREMENT**
- MMR titer - We require documentation of serologic immunity OR two documented MMR vaccines (one since 1980).

**Hepatitis B Series & titer**
- Dates of series:
  - #1
  - #2
  - #3

Booster dates:
- #4: __________________
- #5: __________________
- #6: __________________

Record series dates and attach titer lab report.

**MINIMUM REQUIREMENT**
- Three dose series (second dose one month and third dose six months after first dose) AND a lab report of HBSAB (positive hepatitis surface antibody) titer. If HBSAB result is negative, additional booster required and repeat titer. If negative give doses 5 and 6 then repeat titer 4 weeks later.

**Varicella**
- *titer if titer is negative - Dose #1: __________________

**MINIMUM REQUIREMENT**
- 2 doses of V2V vaccine. OR Varicella titer – (evidence of immunity to Varicella by presenting lab report of positive titer.) * No titer is required if you present 2 V2V vaccine documents.

**SEROLOGIC PROOF IMMUNITY**

<table>
<thead>
<tr>
<th>Test</th>
<th>Date</th>
<th>Positive</th>
<th>Negative</th>
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<tbody>
<tr>
<td>Measles</td>
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<td>Mumps</td>
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<td>Rubella</td>
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<tr>
<td>Varicella</td>
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<tr>
<td>Hepatitis B</td>
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**2 STEP TB TEST**

<table>
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<tr>
<th>Test</th>
<th>Date</th>
<th>Result</th>
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<td>Step 1 Placement</td>
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<tr>
<td>Step 1 Reading</td>
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<tr>
<td>Step 2 Placement</td>
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<tr>
<td>Step 2 Reading</td>
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</table>

Placement date, reading date and results required. Proof of annual testing or 2 step, even for those who have received BCG vaccine as a child. If PPD skin test is positive: DOCUMENTATION IS REQUIRED. In addition, a chest x-ray documenting no active tuberculosis (within 1 year) must be submitted with +PPD documentation. OR a negative Interferon Gamma Release Assay (IGRA).

**REQUIRED**

- 2015 Flu shot
- 2014 Flu shot

**OTHER NOT REQUIRED**

**PRIMARY CARE PROVIDER SIGNATURE REQUIRED - Page 1**

Print Physician Name/Designee ___________________________

Physician/Designee Signature ___________________________ Date: ___________________________

Address ____________________________________________

Phone, with area code (_________) _______________________
This patient has had a recent physical. I find this patient in good health and free of communicable disease. This patient has no restrictions at this time.

Date of Physical __________________

PRIMARY CARE PROVIDER SIGNATURE REQUIRED

Print Physician Name/Designee _____________________________________________
Physician/Designee Signature __________________________________ Date: __________________
Address ___________________________________________________________________
Phone, please include area code _____________________________________________
STATEMENT OF COMPREHENSION

I understand that it is my responsibility to obtain the initial and annual immunization requirements for my program. It is also my responsibility to verify my immunization record is current. I understand that if my records are incomplete by the November 1, 2015 deadline there is a tracking fee of $50.00 that will be applied to my account. I am aware that failure to comply with the requirements of my program will result in additional tracking fees added to my tuition account as well as my program being notified which may result in disciplinary action including suspension from the program.

Student Signature __________________________________ Date: __________________________

Witness Signature __________________________________ Date: ________________________

Here is your checklist:

- All required documentation of vaccines and clinician/physician signed immunization form.
- Email address
- Page 2 of physical assessment including provider signature
- Page 3 student signature and signed statement of comprehension.
- All required lab reports
- Signed FERPA
- UHS student registration form

*Don't forget, items must be on file with UHS before scheduling your review appointment.*

Mail items to:

UC Student Health
4th Floor Holmes
P.O. Box 670460
Cincinnati, OH 45267-0460
FAQ’S

What if I am unable to obtain documentation for my childhood vaccines?

If official documentation is not obtainable from your physician’s office, primary or secondary school or military records, the following is recommended:

1. Receive two-step TB testing (see below)
2. Receive a Tdap.
3. Have the following blood tests drawn – Rubeola antibody IgG, Mumps antibody IgG, Rubella antibody IgG. If you have completed the Hepatitis B series, also have a Hepatitis B Surface antibody test drawn.
4. If you have had chickenpox, have a Varicella antibody IgG drawn. If you have not had chickenpox, receive 2 doses of vaccine.

Do I have to get a MMR titer if I have documentation of two vaccines?

The University of Cincinnati does not require it at this time. However there may be specific clinical sites that would require it. If you cannot provide documentation of 2 MMR vaccines, then a titer will be required. If the titer is negative, a booster will required followed by a repeat titer 30 days later.

I had the Hepatitis B Vaccine years ago but did not get a titer, what should I do?

If you have documentation of all three doses of Hepatitis B Vaccine, have a titer drawn to see if you have antibodies (HBSAB). If the test is negative, get a booster then re-titer in 1-2 months. If this test is negative, you will have to repeat the series then re-titer 1-2 months later. If no documentation is available from your original series, you will need to repeat the series then have a titer drawn 1-2 months later.

I do not have immunity to hepatitis B after receiving 3 vaccines, now what do I do?

Not all individuals will have a positive titer result after the initial 3 vaccinations. A protective antibody response is 10 or more milliinternational units per milliliter (>=10mIU/mL). You will get a booster and then re-titer 1 month later. If at that point you show immunity, you are considered complete. If you are not yet showing immunity you will be receiving a 2 more vaccines and then a final titer four weeks after your last vaccine. After a total of 6 vaccines and final titer you will not be requested to obtain further vaccines.

I had chickenpox - do I have to have varicella titer?

YES. Most people who have had the disease will develop antibodies; however because there are some that may not, a titer is required. We have found about 8% of our health profession students with a history of disease have negative titers. Some histories are not totally reliable. For these reasons, we have to be 100% certain that we do our part to prevent the spread of this disease to our patients. If your titer is positive, no further action is necessary. If your test is negative, you will have to get 2 doses of varicella vaccine.

I had two doses of Varicella vaccine - do I need to have a titer drawn?

No, the requirement is either a positive Varicella titer (VZVIGG) OR 2 doses of the Varicella vaccine. A titer after the vaccine is not required.

What is a Two-step TB test and do I need it?

A two-step TB test is simply having a TB test administered, then having another one administered 1-3 weeks later. If you receive annual TB tests, you can submit your last 2 testing dates to meet the TB requirement. If you have not had a TB test within the past 2 years you will need to obtain a two-step test. Two-step testing is required for the initial skin testing of adults who are going to be tested periodically, such as health care workers. This two-step approach can reduce the likelihood that a boosted reaction to a subsequent skin test will be misinterpreted as a recent infection. For more information on two-step testing: www.cdc.gov/tb

Why does UC Health Student Health use secure e-mail to communicate with me?

UC Health Student Health has taken measures to secure electronic transmission of your personal information. The secure email will be sent via your UC email address. Failure to read these messages will result in your program being notified. Please be sure to check your junk mail folder on a regular basis for these messages.
UC Health, University Health Services Registration Form

Student: Please fill out all 8 sections of this form in its entirety.

Please be prepared to present your insurance card and photo ID. If you are faxing or mailing this form, please include a copy of your insurance card front and back. Secure Fax number: Holmes (513) 584-2222

<table>
<thead>
<tr>
<th>Section</th>
<th>Details</th>
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<tbody>
<tr>
<td><strong>1</strong></td>
<td><strong>Patient Identifiers</strong></td>
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<tr>
<td></td>
<td><strong>Name (Last, First, Middle)</strong></td>
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<tr>
<td></td>
<td><strong>Name you would like to be called? (Nickname)</strong></td>
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<td></td>
<td><strong>Social Security Number</strong></td>
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<td><strong>Birth Date</strong></td>
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<td><strong>Gender</strong> <em>Please Circle one:</em> Male / Female</td>
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<td><strong>Student ID (M) Number</strong></td>
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<td><strong>2</strong></td>
<td><strong>Patient Demographics</strong></td>
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<td><strong>Address</strong></td>
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<td><strong>Apt./ Unit #</strong></td>
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<td><strong>Home Phone</strong> <em>Include area code (  )</em></td>
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<td><strong>Work Phone</strong> <em>Include area code (  )</em></td>
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<td><strong>Mobile Phone</strong> <em>Include area code (  )</em></td>
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<td><strong>Phone number preferred?</strong> <em>Please Circle one:</em> Home / Mobile / Work</td>
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<td><strong>Email Address</strong></td>
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<td><strong>3</strong></td>
<td><strong>Employment Status</strong></td>
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<td><strong>Please Circle One</strong></td>
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<td></td>
<td><strong>Full Time Student / Part Time Student</strong></td>
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<td><strong>If you are employed full time please complete section below, otherwise go on to section 4</strong></td>
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<td><strong>Employer</strong></td>
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<td><strong>Employment Address</strong></td>
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<td><strong>Employment Date</strong></td>
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<td><strong>Employment Zip code</strong></td>
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<td><strong>Occupation</strong></td>
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<td><strong>Phone</strong></td>
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<td><strong>4</strong></td>
<td><strong>Emergency Contact</strong></td>
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<td><strong>Address</strong></td>
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<td><strong>Zip Code</strong></td>
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<td><strong>List country if other than USA</strong></td>
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<td><strong>Relationship to Patient?</strong> <em>Please Circle one:</em> Parent, Grandparent, Relative, Significant Other, Friend, Room Mate</td>
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<td><strong>Hearing Impaired?</strong> <em>Please Circle one:</em> Yes No</td>
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<td><strong>Visually Impaired?</strong> <em>Please Circle one:</em> Yes No</td>
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<td><strong>Spoken Language English?</strong> <em>Please Circle one:</em> Yes No <em>If No, please list:</em></td>
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<td><strong>Interpreter needed?</strong> <em>Please Circle one:</em> Yes No</td>
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<td><strong>Home Phone</strong> <em>Include area code (  )</em></td>
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<td><strong>Mobile Phone</strong> <em>Include area code (  )</em></td>
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<td></td>
<td><strong>Phone number preferred?</strong> <em>Please Circle one:</em> Home / Mobile / Work</td>
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<td><strong>Would you want your emergency contact notified upon admission to the hospital?</strong> <em>Please Circle one:</em> Yes No</td>
</tr>
</tbody>
</table>
**Do you Speak English?**
*Please Circle one*  Yes No If No, please list:

**Do you need an Interpreter?**
*Please Circle one*  Yes No

**Hearing Impaired?**
*Please Circle one*  Yes No

**Visually Impaired?**
*Please Circle one*  Yes No

**How would you like to receive appointment reminders?**
*Please Circle one:*  Text Calls No Calls

**For hospital purposes only, do you have any religious preferences?**
*Please list:* _______________________ or None

**Marital Status:**
*Please Circle one:*  Single Married Significant Other Divorced Separated Widowed

**Ethnicity:**
*Please Circle one:*  Hispanic Non-Hispanic Declined

**Race:**

---

**Primary Care Provider**

**Primary Care Provider Address**

**Primary Care Provider Phone**
*Include area code (       )

---

**The questions below are needed to verify your insurance. Please be sure to answer all questions.**

**Membership relationship to subscriber: Please check one**

- [ ] I am the subscriber of the health insurance.
- [ ] I am the child of the insured.
- [ ] I am the spouse or significant other of the insured.
- [ ] Other Please list:

**CARD INFORMATION**

**Name of Insurance Company**

**Group Number**

**Member Number**

**Member Effective from:**

**Group Name**

**Covered Through Please Circle one:**

- Current Employment
- Retirement
- Cobra (Continuation of benefits)
- Other

**Name of subscriber exactly as it appears on the card:**

**Does patient name appear on card?**
*Please Circle one:*  Yes No Any additional numbers behind name?

**Plan type listed on card**
*Please Circle one:*  HMO, POS, PPO, HDHP, HAS, UNKNOWN

**Verification phone number listed on back of the card:**

**Claim address listed on back of the card:**

---

**SUBSCRIBER INFORMATION**

**Subscriber Name:**

**Subscriber Address**

**Subscriber Zip code**

**Subscriber Birth Date**

**Subscriber Social Security #**

**Subscriber Gender**

- [ ] Male
- [ ] Female

**Subscriber Employer**

**Employment Status**
*Please Circle one:*  Full Time Part Time Retired

**Employment Address**

**Employment Zip code**

**Employment Phone**
*Include area code (       )

**Occupation**

**Does this company have**

- [ ] 1-19 Employees
- [ ] 20-99 Employees
- [ ] 100+ Employees
The privacy of your health information is important to all of us at University Of Cincinnati Health Services. This Notice will tell you about the way we protect that privacy by complying with the Family Educational Rights and Privacy Act (FERPA).

**What is FERPA?**

FERPA is a federal law that protects the privacy of students’ “education records.” The University of Cincinnati follows FERPA regulations because it receives funds that are administered by the U.S. Department of Education. Under FERPA, “Education Records” are very broadly defined as records that are directly related to a student and are kept by an educational agency or institution, or someone acting for the agency or institution.

**How does FERPA apply to my records at University Health Services at UC?**

Under FERPA, the records maintained by University Health Services (UHS) are either “Treatment Records” or “Education Records.” The majority of records maintained at UHS are considered to be “Treatment Records” under FERPA, including the records created by your healthcare provider or counselor while providing you with care. “Treatment records” are records that are made or maintained by a health care professional; are used only for your medical or psychological treatment; and are available only to treatment providers.

**How does UHS use my Treatment Records?**

UHS uses your Treatment Records to provide you with healthcare services. We may disclose your records to other healthcare providers who are also providing you with treatment. In general, we will ask you to sign a written consent form before we provide your information to another healthcare provider for treatment. If there is an emergency situation, however, we may provide this information to other providers for your treatment without having you sign a written consent. At your request, we will also provide your Treatment Records to a physician or other appropriate professional for review.

**Can my Student Health and Counseling Services treatment records be shared with people other than healthcare providers without my consent?**

In general, we will ask you to sign a written consent before we disclose your UHS records to anyone for a purpose other than treatment. In the following circumstances, as permitted by FERPA regulations, we may disclose your UHS records without your written consent: (a) to comply with a judicial order or lawful subpoena; (b) disclosure to the court in connection with a legal proceeding involving the University and you or your parents; and (c) disclosure in connection with a health or safety emergency if knowledge of the information is necessary to protect the health and safety of you or other persons; The FERPA regulations also list other situations in which we may disclose your UHS records without your prior written consent.

**May I make a request to see my UHS records?**
Yes, you may make a written request to see your UHS records. We may provide you with copies of the records or arrange for a healthcare provider to be with you when you review them in order to explain the records and/or answer your questions. However, when your records are disclosed to you in this manner, they are considered Education Records (and no longer Treatment Records) and are covered by FERPA regulations governing Education Records.

At other healthcare providers, I’ve been told that the Health Insurance Portability and Accountability Act (HIPAA) applies to my health records. Why doesn’t HIPAA apply to my UC UHS records?

UHS is covered by both FERPA and HIPAA regulations. Federal regulations make clear that university Education Records and Treatment Records are excluded from coverage under the HIPAA Privacy and Security Rules. Accordingly, the FERPA regulations prescribe the federal rules that UHS must follow in protecting the privacy of a student’s medical and counseling records. If you receive health care from a medical provider outside of University Health Services, then the HIPAA regulations will apply to the records maintained by those facilities. Of course, all UC facilities also comply with any applicable state laws and University policies regarding the privacy and confidentiality of healthcare records, including UHS.

What about counseling or mental health records? In addition to FERPA, there are other state laws that place additional privacy protections and disclosure restrictions on mental health and counseling records, including records held at UHS.

Where may I direct any other questions I may have about the privacy protections for my UC UHS records?

University Rules 10.43.11 and 10.43.13 establish University of Cincinnati procedures for FERPA compliance.

You may contact the UC Director of Privacy at (513) 556-3483.

What if I have a complaint?

FERPA affords students the right to file a complaint with the U.S. Department of Education concerning alleged failures by the University to comply with the requirements of FERPA. The name and address of the Office that administers FERPA is:

Family Policy Compliance Office
U.S. Department of Education
400 Maryland Avenue, SW
Washington, D.C. 20202-5920

I have been informed about the Family Educational Rights and Privacy Act (FERPA).

Name: ____________________________________________

Please Print

Signature: __________________________ Date: __________