Date:        April 1, 2015

TO:          All Matriculating Medical Students – Class of 2019

FROM:  Aurora J. Bennett, M.D.
       Associate Dean, Student Affairs and Admissions

       Philip M. Diller, M.D., PhD
       Interim Director, University Health Services

RE:  Medical Requirements for Enrollment (Due by June 12, 2015)
       University Health Services

Welcome to the University of Cincinnati! University Health Services (UHS) provides health services to faculty, staff, and students of
the University. Further details regarding health services will be provided to you during orientation.

The Immunization History must be completed by your personal physician (not a relative). Please see the time table for document
and review deadlines. Completion and documentation of all immunizations is an absolute requirement for your safety and the
safety of the patients you will serve throughout medical school. Clinical training involving real patients begins in the first year.
YOU WILL NOT BE PERMITTED TO PARTICIPATE IN THE REQUIRED CLINICAL TRAINING ACTIVITIES
UNLESS WE HAVE DOCUMENTATION THAT YOU ARE APPROPRIATELY IMMUNIZED.

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.

If you are covered by a private health insurance plan (your own or your parent’s) we recommend that you carefully review the benefits
it offers before you decide to waive the UC Student Health Insurance (SHI) policy (http://www.uc.edu/uhs). The UC SHI provides a
primary care clinic with board certified physicians and nurse practitioners directly across the street from the Medical Sciences
Building, where most of your classes will be held. The UC policy covers mental health care, specialty referrals, and up to $10,000
coverage for needle sticks and other specific bloodborne pathogen exposures. (The information above is subject to change, please
check with UC Student Health Insurance for the most current information).

In order for your registration to be complete, you MUST have all items on file by the deadline outlined on the time table. You will
be notified by e-mail that you are considered complete or you will be notified if additional records are requested. Additional requested
records will be due no later than July 10. All those failing to meet the initial deadline of June 12th and follow up deadline of July 10th
will be reported to the College of Medicine and expected to schedule a review appointment at the UHS clinic located at the Holmes
Building, 4th Floor [see time table for deadline]. All those who will need time to complete their Hepatitis B series will also need to
schedule a review appointment with UHS. Call (513-584-4457) to make an appointment. Please feel free to contact UHS or the
College of Medicine at if you have any questions.
### REQUIREMENTS

**YOU ARE NOW A STUDENT DOCTOR AND YOU WILL BE IN CLOSE CONTACT WITH SICK PATIENTS. THIS MEANS YOU ARE AT HIGH RISK FOR CERTAIN INFECTIONS AND YOU MAY POSE A HIGH RISK TO VULNERABLE PATIENT POPULATIONS. THE INFORMATION AND REQUIREMENTS BELOW ARE FOR YOUR SAFETY AND THE SAFETY OF THE PATIENTS YOU WILL SERVE.**

**IMMUNIZATION HISTORY – DOCUMENTATION OF IMMUNIZATION MUST BE SIGNED BY YOUR PERSONAL PHYSICIAN/CLINICIAN (not a relative).** FAILURE TO COMPLY MAY RESULT IN SUSPENSION FROM MEDICAL SCHOOL

(Notes from parents and records from baby books are not acceptable.)

*It is suggested that items be mailed at least 2 weeks in advance of this deadline: No e-mailed documents will be accepted.*

<table>
<thead>
<tr>
<th>Required</th>
<th>Tell Me More About This</th>
<th>Deadline – On file with UHS by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ishihara Test</td>
<td>A color blindness test will need to be given and documented by primary care provider. Students with abnormal Ishihara test results will need to report to University Health Services.</td>
<td></td>
</tr>
<tr>
<td>MMR</td>
<td>We require documentation of serologic immunity OR 2 documented MMR (Measles, Mumps, Rubella) vaccines (one since 1980).</td>
<td></td>
</tr>
<tr>
<td>MMR booster if needed</td>
<td>If you do not have 2 documentations of MMR (once since 1980) and/or the MMR titer is negative, a booster will be required.</td>
<td></td>
</tr>
<tr>
<td>Established Hepatitis B documentation</td>
<td>Health care workers are at high risk for Hepatitis B infection. The UC College of Medicine 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. <strong>Immune may, therefore, take up to eight months to complete.</strong></td>
<td></td>
</tr>
<tr>
<td>Chickenpox</td>
<td>All students will be required to have either a positive VZV (Varicella IGG) titer OR provide documentation of two immunization doses. Any susceptible students will be required to receive 2 doses of VZV vaccine.</td>
<td></td>
</tr>
<tr>
<td>Tdap</td>
<td>1 adult Tdap vaccine. (Tetanus, Diphtheria and Pertussis)</td>
<td></td>
</tr>
<tr>
<td><strong>BASELINE AND ANNUAL TB TESTING IS REQUIRED</strong></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. YOU WILL NOT BE PERMITTED TO PARTICIPATE IN CLINICAL ROTATIONS IF YOU ARE NOT IN COMPLIANCE WITH THIS REQUIREMENT. Annual PPD testing is due May 1st of each year that you are enrolled.</td>
<td><strong>All items to the left are due by June 12, 2015</strong></td>
</tr>
<tr>
<td>(Just for students 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. The annual +PPD surveillance form is due May 1st each year that you are enrolled. YOU WILL NOT BE PERMITTED TO PARTICIPATE IN CLINICAL ROTATIONS IF YOU ARE NOT IN COMPLIANCE WITH THIS REQUIREMENT.</td>
<td></td>
</tr>
<tr>
<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>
<td></td>
</tr>
<tr>
<td>Authorization of Release</td>
<td>This form will allow University Health Services to release your immunization records to clinical sites during your clinical rotations.</td>
<td></td>
</tr>
<tr>
<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>
<td></td>
</tr>
<tr>
<td>Review Appointment with UHS (For students needing boosters or starting the series) Hepatitis B</td>
<td>For students with negative titer or just starting the Hepatitis B series a review with University Health Services is required. Please call 513-584-4457 to schedule your appointment. Please note: you will be expected to follow a dosing schedule. All those who do not comply may be subject to a $100.00 tracking fee and will be reported to the College of Medicine.</td>
<td><strong>June 26, 2015</strong></td>
</tr>
<tr>
<td>Pending Vaccine Documentation</td>
<td>All students will be contacted by e-mail once documents are reviewed and additional documentation may be requested by University Health Services. Those requested items or vaccines required to complete varicella or MMR are also included in this deadline.</td>
<td><strong>July 10, 2015</strong></td>
</tr>
<tr>
<td>2015 INFLUENZA VACCINE AND ANNUAL REQUIRED</td>
<td>Documentation of 2015 Flu shot will be required. The deadline will be made by the College of Medicine as soon as the vaccine becomes available. Specific information will be requested for this document, please be sure to obtain the necessary form at that time. <strong>Flu shot required continuing each year of enrollment.</strong></td>
<td>When vaccine is available</td>
</tr>
</tbody>
</table>

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

Review comments will be sent electronically to the e-mail address listed on your submitted form. Please do not ignore these messages, mistake them for junk mail or delete them without reading them as it will be our primary means of communication to you. Failure to read these messages will result in your program being notified. Once classes begin all e-mail messages will be sent to your UC e-mail address. For any questions, please contact the University Health Services clinical staff at 513-584-4457.

### 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 higher insurance and would like to waive the coverage, you must waive on-line by September 7th, 2015. (www.onestop.uc.edu/) or (https://comdo-wcnlib.uc.edu/MedOneStop/FinancialAid/FinancialAid.aspx) 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.
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 July 31, 2016 deadline there is a tracking fee of $100.00 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:____________________

Here is your checklist:

☐ All required documentation of vaccines and clinician/physician signed immunization form.

☐ Email address

☐ All required lab reports

☐ Signed FERPA

☐ Authorization of release of medical information for clinical rotation form

☐ Signed statement of comprehension

☐ UHS student registration form

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

Mail items to:

University Health Services
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 – Rubella 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 milli-international 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 (VZV/IGG) 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 UHS use secure e-mail to communicate with me?

University Health Services has taken measures to secure electronic transmission of your personal information. The secure email will be sent via your UC email address from University Health Services electronic medical records system. Follow the instructions in the e-mail to retrieve your personal health information message. Please do not ignore these messages, mistake them for junk mail or delete them without reading them as it will be our primary means of communication to you. Failure to read these messages will result in your program being notified. Please remember to check your junk mail folder often.
### UNIVERSITY HEALTH SERVICES IMMUNIZATION HISTORY (To be completed by a physician)

**Patient Name:**

**DOB (mm/dd/yyyy):**

**Student ID M**

**REQUIRED: e-mail address** (for confirmation of completed requirements or follow-up request):

### COLLEGE OF MEDICINE REQUIRED IMMUNIZATIONS

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Requirement</th>
<th>Dates/Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>DPT/Tdap</td>
<td>5 childhood doses and booster every 10 years</td>
<td>#1 #2 #3 #4 #5 Did not receive 1 Adult Tdap dose given: Date</td>
</tr>
<tr>
<td>Polio</td>
<td>3 childhood doses and booster: *Booster date required:</td>
<td>#1 #2 #3 Booster</td>
</tr>
<tr>
<td>MMR</td>
<td>MMR #1 #2: If titer is negative, booster and Re-titer: 4 weeks after booster</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>If given separately: Mumps #1 #2 Measles (Rubella) #1 #2 Rubella #1 #2</td>
<td></td>
</tr>
<tr>
<td>Varicella</td>
<td>If titer is negative: Dose #1 #2</td>
<td></td>
</tr>
<tr>
<td>Hepatitis A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningococcal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BCG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flu shot</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HPV Vaccine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### SEROLOGIC PROOF IMMUNITY

<table>
<thead>
<tr>
<th>Test</th>
<th>Date of Test</th>
<th>Positive</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles</td>
<td>/</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>Mumps</td>
<td>/</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>Rubella</td>
<td>/</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>Varicella</td>
<td>/</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>/</td>
<td>/</td>
<td>/</td>
</tr>
</tbody>
</table>

**Ishihara Test**

<table>
<thead>
<tr>
<th>Date of Test</th>
<th>Ishihara’s within normal limits</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 2 STEP TB TEST

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

### OTHER NOT REQUIRED

- Hepatitis A Vaccine Date:
- Meningococcal Vaccine Date:
- BCG Yes (Date: ) No
- Flu shot (Last dose received) Date:
- HPV Vaccine (Women only) 1st Dose 2nd Dose 3rd Dose
- Other

### PRIMARY CARE PROVIDER SIGNATURE REQUIRED

Print Physician Name/Designee __________________________

Physician/Designee Signature __________________________ Date: __________________________

Address ____________________________________________

Phone, with area code (__________) ______________________
# 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

## Patient Identifiers

<table>
<thead>
<tr>
<th>Section</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Name (Last, First, Middle)</td>
</tr>
<tr>
<td></td>
<td>Name you would like to be called? (Nickname)</td>
</tr>
<tr>
<td></td>
<td>Social Security Number</td>
</tr>
<tr>
<td></td>
<td>Birth Date</td>
</tr>
<tr>
<td></td>
<td>Gender Please Circle one: Male / Female</td>
</tr>
<tr>
<td></td>
<td>Student ID (M) Number</td>
</tr>
</tbody>
</table>

## Patient Demographics

<table>
<thead>
<tr>
<th>Section</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Address</td>
</tr>
<tr>
<td></td>
<td>Apt./ Unit #</td>
</tr>
<tr>
<td></td>
<td>Zip code</td>
</tr>
<tr>
<td></td>
<td>Home Phone Include area code ( )</td>
</tr>
<tr>
<td></td>
<td>Work Phone Include area code ( )</td>
</tr>
<tr>
<td></td>
<td>Mobile Phone Include area code ( )</td>
</tr>
<tr>
<td></td>
<td>Phone number preferred? Please Circle one: Home / Mobile / Work</td>
</tr>
<tr>
<td></td>
<td>Email Address</td>
</tr>
</tbody>
</table>

## Employment Status

<table>
<thead>
<tr>
<th>Section</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Please Circle One Full Time Student / Part Time Student</td>
</tr>
<tr>
<td></td>
<td>If you are employed full time please complete section below, otherwise go on to section 4</td>
</tr>
<tr>
<td></td>
<td>Employer</td>
</tr>
<tr>
<td></td>
<td>Employment Address</td>
</tr>
<tr>
<td></td>
<td>Employment Date</td>
</tr>
<tr>
<td></td>
<td>Employment Zip code</td>
</tr>
<tr>
<td></td>
<td>Occupation</td>
</tr>
<tr>
<td></td>
<td>Phone</td>
</tr>
</tbody>
</table>

## Emergency Contact Information

<table>
<thead>
<tr>
<th>Section</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Emergency Contact</td>
</tr>
<tr>
<td></td>
<td>Address</td>
</tr>
<tr>
<td></td>
<td>Zip Code</td>
</tr>
<tr>
<td></td>
<td>List country if other than USA</td>
</tr>
<tr>
<td></td>
<td>Relationship to Patient? Please Circle one: Parent, Grandparent, Relative, Significant Other, Friend, Room Mate</td>
</tr>
<tr>
<td></td>
<td>Hearing Impaired? Please Circle one: Yes No</td>
</tr>
<tr>
<td></td>
<td>Visually Impaired? Please Circle one: Yes No</td>
</tr>
<tr>
<td></td>
<td>Spoken Language English? Please Circle one: Yes No If No, please list:</td>
</tr>
<tr>
<td></td>
<td>Interpreter needed? Please Circle one: Yes No</td>
</tr>
<tr>
<td></td>
<td>Home Phone Include area code ( )</td>
</tr>
<tr>
<td></td>
<td>Work Phone Include area code ( )</td>
</tr>
<tr>
<td></td>
<td>Mobile Phone Include area code ( )</td>
</tr>
<tr>
<td></td>
<td>Phone number preferred? Please Circle one: Home / Mobile / Work</td>
</tr>
</tbody>
</table>

Would you want your emergency contact notified upon admission to the hospital? Please Circle one: Yes No
### 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

- **Name:**  
- **Address:**  
- **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
UNIVERSITY HEALTH SERVICES
AUTHORIZATION OF RELEASE OF MEDICAL INFORMATION

<table>
<thead>
<tr>
<th>Section in blue must be filled out completely</th>
<th>PATIENT INFORMATION</th>
<th>Section in blue must be filled out completely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name</td>
<td>First</td>
<td>Middle</td>
</tr>
<tr>
<td>Address</td>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>M Number</td>
<td>SS Number</td>
</tr>
</tbody>
</table>

Agency/Hospital
Name & Title of Person
Street Address
City, State, & Zip
Phone & Fax including area code

FROM
University Health Services
4th Floor Holmes
P.O. Box 670460
Cincinnati, OH 45267-0460
513-584-4457

TO
As Requested

□ Inpatient
□ Same Day Surgery
□ Outpatient Clinics
□ Emergency Department

Information Needed

Pertinent summary documents (*) from the above visits will be sent, unless specific reports are indicated below:

□ Face Sheet*
□ History & Physical
□ Discharge Summary*
□ Operative Reports*
□ Pathology Reports*
□ Consultation Reports*
□ Lab Reports*
□ X-Ray Reports*
□ Test Reports*
□ Therapy Records
□ Emergency Treatment
□ Immunization Records
□ Other__________________________

Reason Needed

Pertinent summary documents (*) from the above visits will be sent, unless specific reports are indicated below:

□ Medical Care
□ Disability
□ Insurance
□ Legal Reasons
□ Clinical Rotations

This consent will expire in four (4) years after the date below, or sooner by my choice in which case this consent will expire on: ____________________ I have the right to revoke this consent at any time by informing University Health Services in writing.

□ I hereby authorize University Health Services to release the medical information stated above for the reason and time specified.

I give permission to release information concerning treatment, diagnosis, or testing of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological conditions, Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC) and/or test antibodies to the AIDS virus (HIV).

Patient/Guardian* Signature       Date       Witness Signature

* Reason patient is unable to sign_____________________________________________________

(Provide guardianship, executor or estate, power of attorney papers if required.)

Revised 3/2015 COM student clinical rotation health records release
University of Cincinnati
University Health Services
Notice Regarding Confidentiality of Health Records
Family Educational Rights & Privacy Act (FERPA)

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 or 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:  _______________