TO: Matriculating Health Professions Students/ Medical Laboratory Science

FROM: Philip Diller, MD
Interim Director, University Health Services

RE: Medical Requirements for Enrollment
University Health Services

Welcome to the University of Cincinnati! University Health Services (UHS) provides comprehensive health services to staff, faculty and students of the University. University Health Services tracks immunizations for many UC programs with immunization requirements.

The attached Immunization History form must be completed by your personal physician (not a relative) and promptly returned to UHS. 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, authorization of medical release of information form, and UHS registration form.

In order for your registration to be complete, - you must schedule an appointment to be seen at University Health Services. Location: Holmes Building, 4th Floor, [see time table for deadline]. This visit will allow us to review your history with you as well as familiarize you with our services. Call 513-584-4457 to make an appointment. Please feel free to contact our office if you have any questions.

FYI: College of Allied Health students will be charged a $20.00 fee for the immunization registration appointment at the time of visit. If your immunizations are complete (including the entire Hepatitis B series) and documented by your physician as requested by the deadline listed below, you will be marked as complete and not charged any tracking fees.

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 and tracking fees - due at the time of your review appointment may be charged to your UC student account if desired.

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

Rev. 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. April 15 – July 31</td>
<td>Required Review &amp; Ishihara Test (color blind testing)</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 dates: <em>April 15, 2015 – July 31, 2015</em></td>
</tr>
<tr>
<td>MMR</td>
<td>We require documentation of serologic immunity OR 2 documented MMR (Measles, Mumps, Rubella) vaccines (since 1980).</td>
<td></td>
</tr>
<tr>
<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>
<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 Allied Health 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>
<td></td>
</tr>
<tr>
<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 titer, 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 August 31, 2015 and will automatically be charged the tracking $50.00 fee.</td>
<td></td>
</tr>
<tr>
<td>Chickenpox</td>
<td>All students will have to receive 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>VZV Vaccine if needed</td>
<td>No vaccine history or negative titer. 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>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 &quot;2-step&quot; 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.</td>
<td></td>
</tr>
<tr>
<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>
<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>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>
</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 the College of Allied Health 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 June 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 June 1, 2016 deadline. Adhering to your recommended dosing schedule will not result in the additional fee associated with the June 1, 2016 deadline. However please note that if you do not adhere to the dosing schedule this 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

The University of Cincinnati requires those enrolled in the University Health Insurance Plan to provide documentation of immunization and physical examination. If you have equal or better insurance and would like to waive the coverage, you must first log in and fill out the online application. If you have equal or better insurance, you may select the Student Health Insurance Plan and waive coverage. If you have equal or better insurance and you would like to waive the coverage, you must waive on-line by September 7, 2015. ([www.onestop.uc.edu/](http://www.onestop.uc.edu/)) If you do not have University Health Insurance, please visit ([www.uc.edu/uhs](http://www.uc.edu/uhs)) to select the Student Health Insurance Plan and submit your application. 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/](http://www.onestop.uc.edu/))

**Bloodborne Pathogen Exposure Insurance** will not be required for any student who does not have UC Student Health Insurance. The premium is automatically assessed to the tuition bill. ([http://www.uc.edu/uhs/student_health_insurance/bloodborne_pathogen_exposureinsurance.html](http://www.uc.edu/uhs/student_health_insurance/bloodborne_pathogen_exposureinsurance.html))

4/2015
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 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: __________________________

Here is your checklist:

- All required documentation of vaccines and clinician/physician signed immunization form.
- Email address
- All required lab reports
- Signed FERPA
- Signed statement of comprehension
- Signed authorization of release of medical information
- UHS 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
**UNIVERSITY HEALTH SERVICES IMMUNIZATION HISTORY (To be completed by a physician)**

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

Student ID: ___________________________  M ___________________________

**e-mail address required - please write legibly:**

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**COLLEGE OF ALLIED HEALTH – MEDICAL LABORATORY SCIENCE**

**DPT/ Tdap**

- 5 childhood doses and booster every 10 years
- Dates of primary series:
  - #1: ________
  - #2: ________
  - #3: ________
  - #4: ________
  - #5: ________
- Did not receive ☐  No record ☐
- 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**

- 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 given doses 5 and 6 then repeat titer 4 weeks later.

**Varicella**

- *No titer is required if you present 2 VZV vaccine documents.

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**2 STEP TB TEST**

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

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**OTHER NOT REQUIRED**

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Date</th>
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<tbody>
<tr>
<td>Hepatitis A Vaccine</td>
<td>Date:</td>
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<tr>
<td>Meningococcal Vaccine</td>
<td>Date:</td>
</tr>
<tr>
<td>BCG</td>
<td>Yes (Date: ________ ) No</td>
</tr>
<tr>
<td>Flu shot:</td>
<td>2014 Date:</td>
</tr>
<tr>
<td>HPV Vaccine</td>
<td>1st Dose</td>
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<td></td>
<td>Other</td>
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</tbody>
</table>

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**PRIMARY CARE PROVIDER SIGNATURE REQUIRED**

Print Physician Name/Designee: ___________________________  Date: ___________________________

Physician/Designee Signature: ___________________________  Date: ___________________________

Address: ____________________________________________

Phone, with area code (_________): ___________________________
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 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 request 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 titters. 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 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.
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>Information</th>
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<tbody>
<tr>
<td>1</td>
<td><strong>Patient Identifiers</strong></td>
</tr>
<tr>
<td></td>
<td>Name (Last, First, Middle)</td>
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<td></td>
<td>Name you would like to be called? (Nickname)</td>
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<td></td>
<td>Social Security Number</td>
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<td>Birth Date</td>
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<td>Gender</td>
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<td></td>
<td>Student ID (M) Number</td>
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<tr>
<td>2</td>
<td><strong>Patient Demographics</strong></td>
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<td></td>
<td>Address</td>
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<td>Apt./ Unit #</td>
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<td>Zip code</td>
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<td>Home Phone Include area code ( )</td>
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<td>Mobile Phone Include area code ( )</td>
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<td>Phone number preferred?</td>
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<td></td>
<td>Email Address</td>
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<td>3</td>
<td><strong>Employment Status</strong></td>
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<td>Please Circle One</td>
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<td>If you are employed full time please complete section below, otherwise go on to section 4</td>
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<td></td>
<td>Employer</td>
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<td></td>
<td>Employment Address</td>
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<td>Employment Date</td>
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<td>Employment Zip code</td>
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<td>Occupation</td>
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<td>4</td>
<td><strong>Emergency Contact</strong></td>
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<td>Address</td>
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<td>Zip Code</td>
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<td>List country if other than USA</td>
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<td>Relationship to Patient?</td>
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<td>Hearing Impaired?</td>
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<td>Visually Impaired?</td>
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<td>Spoken Language English?</td>
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<td></td>
<td>Interpreter needed?</td>
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<td>Home Phone Include area code ( )</td>
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<td>Work Phone Include area code ( )</td>
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<tr>
<td></td>
<td>Mobile Phone Include area code ( )</td>
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<td></td>
<td>Phone number preferred?</td>
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<tr>
<td></td>
<td>Would you want your emergency contact notified upon admission to the hospital? Please Circle one: 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:**

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**Primary Care Provider**

**Primary Care Provider Address**

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

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**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>Last Name</th>
<th>First</th>
<th>Middle</th>
<th>Maiden</th>
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<thead>
<tr>
<th>Date of Birth</th>
<th>M Number</th>
<th>SS Number</th>
<th>Area Code + Phone Number</th>
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</table>

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

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

**TO**
As Requested

**INFORMATION NEEDED**
- Lab Reports*
- X-Ray Reports*
- Immunization Records
- Other____________________________

**REASON NEEDED**
- X 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.

- X 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 5/2015 MLS student clinical rotation health records release
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: ______________