UNIVERSITY of VIRGINIA
SCHOOL of EDUCATION and HUMAN DEVELOPMENT
Sheila C. Johnson Center

Sheila C. Johnson Center
417 Emmet Street
P.O. Box 400270
Charlottesville, VA 22904-4270
Phone: 434-924-7034 • Fax: 434-924-4621
education.virginia.edu/research-initiatives/sheila-c-johnson-center

Authorization to Release and Receive Confidential Healthcare Information

Client Name: **Date of Birth:** **Best Contact Phone #:**

Street Address: **State:** **Zip Code:**

I hereby authorize the Sheila C. Johnson Center (SJC), at the University of Virginia to release and/or receive:

Copies of Health Records (select all that apply):

- ☐ Audiological Information
- ☐ Hearing Aid Information
- ☐ McGuffey Reading Evaluation
- ☐ McGuffey Reading Documentation
- ☐ Speech-Language Evaluation
- ☐ Speech-Language Clinical Documentation
- ☐ Psychological/Educational Testing
- ☐ Psychological Clinical Documentation
- ☐ Intake/Discharge Summary
- ☐ School Records
- ☐ Report Cards
- ☐ Standardized Test Results
- ☐ Special Education/504 Records
- ☐ Therapist/School/Teacher Input
- ☐ Attendance Records
- ☐ Discipline Records
- ☐ Behavior Checklist
- ☐ Classroom Observation
- Other: _____
- Other: _____
- Other: _____

Exclusions (if applicable):_____

I understand that I am giving my permission to release information in my health record that may include information relating to psychiatric treatment, drug/alcohol treatment. AIDS/HIV testing or treatment of sexually transmitted disease, unless indicated in the following instructions: _____

Release of information from SJC to: *(identify organization)* _____
Name (Physician, hospital, agency, organization, individual etc.

_____
Street Address, City, State and Zip Code

Signee initial the request: _____

_____ _____
Phone **Fax**

Release of information from *(identify organization)* to SJC _____
Name (Physician, hospital, agency, organization, individual etc.

_____
Street Address, City, State and Zip Code

Signee initial the request: _____

_____ _____
Phone **Fax**

Purpose of Disclosure: ☐ **Personal** ☐ **Insurance** ☐ **Attorney** ☐ **Workers Comp** **Other**

I hereby authorize disclosure of the health information for the above-named client. This authorization is valid for 12 months from the date of the signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information disclosed may be subject to re-disclosure by the person or facility receiving it and would then no longer be protected by federal regulations. I understand that the Sheila C. Johnson Center may not condition its providing of health care on whether copies to individuals or organizations are released as I request.

_____

Signature of Client or Legal Representative (electronic signature is not acceptable) **Date**

If completed on OnPatient an electronic signature is acceptable. Onpatient User ID and Password serves as a signature.

If I am not the client and am signing as the client's legal (authorized) representative, I attest that the client lacks the capacity to make the decision to release the health record as specified above.

_____

Client's Authorized Representative (electronic signature is not acceptable) **Date**

If completed on OnPatient an electronic signature is acceptable. Onpatient User ID and Password serves as a signature

**** Not to be included in the UVa Health Care Designation Record Set****