PURPOSE: To provide documentation, per patient request, for missed class/work time due to extended illness or injury.

POLICY:
Students who are seeking documentation of illness/injury for class/work absence will only be allowed to see a Student Health Services provider when two conditions are met:
- Patient has received care/treatment by SHS or has documentation of treatment provided by another healthcare provider; **AND**
- Patient has three or more consecutive days of absence due to extended illness or injury.

Students who do not meet the above criteria will be provided an Authorization for Use/Disclosure to obtain documentation that they were treated by SHS.

PROCEDURES:
1. Whenever the Registration person is aware the student is requesting documentation of illness, it will be that person’s responsibility to explain the policy.
   1.1 Students who qualify under this policy will be allowed to see a provider.
   1.2 Providers may choose to handwrite an explanation for the class absence using the small “Physician Memorandum” form as in the past, or they may choose to create a free-text clinical letter within the patient’s electronic health record (EHR) containing more detailed information to explain the absence. This letter is then printed and given to the patient.

2. Patients who do not qualify under this policy to see a provider can complete an Authorization for Use/Disclosure upon which they must check the box, “I am requesting a copy of the documentation regarding my Illness / Injury.” Also, patients must choose whether or not they want to include their diagnosis.
   2.1. Marking the check box for **Include my diagnosis** will result in the following process:
       2.1.1. The encounter note/s will be printed from the patient’s EHR.
       2.1.2. Information requested will be provided or mailed as designated on Authorization.
       2.1.3. Charges will be assessed according to the R&R Fee Schedule.
       2.1.4. Patients are to be told that this process may take up to 48 hours to complete and will be processed in a first-in/first-out basis with all such requests for information.
2.2. Marking the check box for “DO NOT include my diagnosis” will result in:

2.2.1. An “Appointment Confirmation Letter” (ACL) being generated from Point and Click. The ACL is a pre-formatted letter that does not contain clinical information but automatically contains:

- Patient’s name
- KU ID number
- Date & Time of the appointment
- Date & Time checked-in
- Name of Nurse or Provider who saw the patient.

2.2.2. No Charge being assessed if the patient chooses to pick up the documentation. If the information is to be mailed or faxed, charges will be assessed according to the R&R Fee Schedule, i.e., the minimum charge for labor and supplies.

2.2.3. Patients being told that this process may take up to 48 hours to complete and will be processed on a first-in/first-out basis with all such requests for information.

3. If patient elects to pick-up his/her copies of documentation rather than having them mailed or faxed, R&R will maintain a convenient file of completed requests to facilitate this pick-up process.

4. On occasion, a patient will not indicate to R&R that s/he is seeking documentation of illness/injury and will be seen by a provider who will subsequently learn that this was the purpose of the patient’s visit. When this occurs, the same rules apply as stated above. If the patient does not qualify for a provider’s documentation of illness, the patient is referred to R&R for completion of an Authorization for Use/Disclosure (step #2).