Vanderbilt University Medical Center

Medical record #_____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

☐ **PATIENT IDENTIFICATION:** Name:_____

Patient Phone#_____ Date of Birth_____ S.S.# _____

PROVIDER: (Who is releasing information) **Vanderbilt University Medical Center**

☐ **RELEASE RECORDS TO:** Name:_____

(Person or Place records should be sent)

Address:_____

Phone# :_____

City:_____

Fax# : _____

State/Zip_____

☐ **DATES OF TREATMENT:** Dates:_____

☐ **INFORMATION REQUESTED:**

- ❑ HOSPITAL STAY
- ❑ EMERGENCY ROOM
- ❑ OBSTETRICS and (LABOR and DELIVERY)
- ❑ PSYCHIATRIC HOSPITAL OR CLINICS
- ❑ CLINIC:
- ❑ **OTHER (specify):**

☐ **PURPOSE OF RELEASE:**

❑ Medical Care ❑ Insurance ❑ At the request of the patient

❑ Other, Please Explain:_____

I understand that my medical record may also include information on diagnosis/treatment related to **psychiatric or psychological conditions, drug and/ or alcohol abuse, acquired immune deficiency syndrome (AIDS), and/ or HIV status**.

I understand and agree that the information, if any, pertaining to any such diagnosis/treatment described above may be released.

☐ **PLEASE INITIAL THE STATEMENT THAT APPLIES**

(You must initial one)

I do_____ do not_____ authorize this information to be released.

Limitations, if any:_____

☐ **TIME LIMIT:** I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition_____

Signature of Patient/Legal Representative:_____Date:_____

Relationship to Patient:_____

OTHER TYPES OF RECORDS THAT MAY BE OBTAINED:	
HOME CARE SERVICES: 615-936-0336 2120 Bell Court Avenue Nashville, TN 37212	**RADIOLOGY FILMS:** **Radiology Film Library** **615-322-6311** **1211 22nd Avenue South** **1098 VUH** **Nashville, TN 37232-2675**
PHARMACY (Outpatient) 615-322-6480 **1301 22nd Ave. S.** Nashville, TN 37232-5611	**FINANCIAL OR BILLING RECORDS:** **Patient Accounting Offices** **615-936-0910** **2135 Blakemore - 37212** **Nashville, TN 37212-3505**

How to REVOKE your Authorization for Release of Medical Information

You have the right to revoke your Authorization for Release of Medical Information. To do so you must send us a written letter revoking your authorization. The letter should be mailed to the following address:

Vanderbilt University Medical Center
Medical Information Services- Release of Information
1211 22nd Avenue South
Nashville, TN 37232-7350

If you have any questions please call our Release of Information department at 615-322-2062

Exceptions: This authorization may be revoked except to the extent that:

1. VUMC has taken action in reliance thereon: or
2. If the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim under the policy or the policy itself.

PLEASE NOTE:

When your Medical information is released pursuant to a valid authorization you should be aware of the following:

That the information released may be subject to re-disclosure by the recipient and may no longer be protected by the Privacy Rule.

TREATMENT MAY NOT be withheld, or conditioned on obtaining this authorization.