Vanderbilt University Medical Center

Medical record #_____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT IDENTIFICATION	Name:_____ Date of Birth_____ S.S.#_____ Maiden/Other names known by:
PROVIDER **(Who is releasing information)**	**Vanderbilt University Medical Center**
RELEASE RECORDS TO: **(Person or Place records should be sent)**	Name:_____ Address:_____ City/State/Zip_____
DATES OF TREATMENT	Dates:_____

INFORMATION REQUESTED FROM:

HOSPITAL STAY	**PSYCHIATRIC HOSPITAL OR CLINICS**
EMERGENCY ROOM	**Vanderbilt HOME HEALTH**
OBSTETRICS & (LABOR & DELIVERY)	**PHARMACY (outpatient)**
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**.

PLEASE INITIAL THE STATEMENT THAT APPLIES
(You must initial one)

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

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:_____

THERE WILL BE A CHARGE FOR COPIES OF YOUR MEDICAL RECORD UNLESS THE COPIES ARE BEING SENT TO ANOTHER PHYSICIAN OR HEALTHCARE FACILITY

Other information that may be requested:

ADDITIONAL CLINIC REQUESTS CLINIC:	OTHER TYPES OF RECORDS THAT MAY BE OBTAINED:
CLINIC:	RADIOLOGY FILMS: Radiology Film Library 615-322-6311 1211 22nd Avenue South 1098 VUH Nashville, TN 37232-2675
CLINIC:	
CLINIC:	FINANCIAL OR BILLING RECORDS: Patient Accounting Offices 615-936-0910 2135 BLAKEMORE AVE NASHVILLE TN 37212-3505
CLINIC:	

***THERE WILL BE A CHARGE FOR COPIES OF YOUR MEDICAL RECORD* UNLESS THE COPIES ARE SENT TO ANOTHER PHYSICIAN OR HEALTHCARE FACILITY.**

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 do not wish to write a letter you may fill out the following form and mail it to the address above:

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.

REVOCATION OF AUTHORIZATION

Name: _____

Date of Birth: _____

Address: _____

I, _____wish to revoke my Authorization for the Release of Medical Information

to: _____
(Person or place records should **not** be sent)

I also realize in the event that these records have *already* been released by valid authorization that these records cannot be retracted.

Signature of Patient/Legal Representative:_____ Date:_____

Relationship to Patient:_____

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.