

Vanderbilt Health
Communication with Family and Others
about Your Care and
Permission to See Your Medical Record
Authorization (P) - Communication with Family and Others



Patient Label or Patient Identifiers

Name: _____

Date of Birth: _____

List family members or others you want to be involved with coordinating your care or payment for care at Vanderbilt University Medical Center (VUMC). Be sure to check the box to show which kinds of information may be shared with each person. If anyone listed below works at VUMC, you can show whether you want that person to see your medical record by checking, or not checking, the "view my medical record" box.

1. Name _____ Phone _____
Relationship to patient _____ Date Permission Expires _____ Never

This person has permission to:

- Communicate with my health care providers
- Know about billing and insurance
- Know about and schedule appointments
- Know genetic information only
- View my medical record
- Other: _____

2. Name _____ Phone _____
Relationship to patient _____ Date Permission Expires _____ Never

This person has permission to:

- Communicate with my health care providers
- Know about billing and insurance
- Know about and schedule appointments
- Know genetic information only
- View my medical record
- Other: _____

3. Name _____ Phone _____
Relationship to patient _____ Date Permission Expires _____ Never

This person has permission to:

- Communicate with my health care providers
- Know about billing and insurance
- Know about and schedule appointments
- Know genetic information only
- View my medical record
- Other: _____

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4. Name _____ Phone _____
Relationship to patient _____ Date Permission Expires _____ Never

This person has permission to:

- | | |
|--|--|
| <input type="checkbox"/> Communicate with my health care providers | <input type="checkbox"/> Know genetic information only |
| <input type="checkbox"/> Know about billing and insurance | <input type="checkbox"/> View my medical record |
| <input type="checkbox"/> Know about and schedule appointments | <input type="checkbox"/> Other: _____ |

OPTIONAL: (NOT FOR CLINIC USE)

During your stay, if you give us a code word, we will share your information with anyone that provides your code word.

Your Code word: _____

We will use the information on this form when communicating with family members or others involved in your care unless you ask for a change. It is your responsibility to tell the Privacy Office right away if you have a change in marital status, child custody arrangements, or other life events that affect this permission. This authorization will expire when a minor patient reaches the age of 18.

Patient/Legal Representative Print Name: _____

Patient/Legal Representative Signature: _____

Relation: _____ Date: _____ Time: _____

You may get a copy of this completed form.

To cancel or change this permission, send a written request with a copy of this form to:

Vanderbilt University Medical Center Privacy Office
3841 Green Hills Village Drive, Suite 200
Nashville, TN 37215

If you have any questions, call the VUMC Privacy Office at (615) 936-3594.

Fax completed form to (615)-343-6966