Student Health Center

Vanderbilt University Medical Center

Authorization for Release of Medical Information

Authorization (P) *Release of Medical Information*

As a Vanderbilt University student, I authorize Vanderbilt University Medical Center Student Health Center to share my immunization record with Vanderbilt University Medical Center Occupational Health Clinic. I understand that my records will be reviewed and additional vaccinations and/or medical health requirements may need to be met for employment at Vanderbilt University Medical Center

Name: ____

Date of Birth: ______________________________________

Student Email Address: _______________________________________@vanderbilt.edu

Patient/Legal Representative Print Name: ______________________________________

Patient/Legal Representative Signature: ______________________________________

Relation: ______________________________ Date: ___________ Time: _________

Return this form to:

Clinic Manager

Student Health Center

Vanderbilt University Medical Center

1210 Stevenson Center Lane

Nashville, TN 37232-8710

office 615-322-2427

fax 615-343-0047

studenthealth@vumc.org

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