Student Health Center
Vanderbilt University Medical Center
Authorization for Release of Medical Information
Authorization (P) *Release of Medical Information*

Patient Label or Patient Identifiers

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:

Dara L. Dixon, RN, BSN, Assistant Nurse Manager
Student Health Center
Vanderbilt University Medical Center
1210 Stevenson Center Lane
Nashville, TN 37232-8710
office 615-343-6186
fax 615-343-0047
dara.l.grissom@vanderbilt.edu

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