

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:		
<input type="checkbox"/> HOSPITAL STAY	<input type="checkbox"/> PSYCHIATRIC HOSPITAL OR CLINICS	
<input type="checkbox"/> EMERGENCY ROOM	<input type="checkbox"/> Vanderbilt HOME HEALTH	
<input type="checkbox"/> OBSTETRICS & (LABOR & DELIVERY)	<input type="checkbox"/> PHARMACY (outpatient)	
<input type="checkbox"/> CLINIC:	<input type="checkbox"/> OTHER (specify):	
PURPOSE OF RELEASE	<input type="checkbox"/> Medical Care <input type="checkbox"/> Insurance <input type="checkbox"/> At the request of the patient <input type="checkbox"/> Other, Please Explain: _____	
<p>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.</p> <p>I understand and agree that the information, if any, pertaining to any such diagnosis/treatment described above may be released.</p> <p>PLEASE INITIAL THE STATEMENT THAT APPLIES (You must initial one)</p> <p>I do _____ do not _____ authorize this information to be released. Limitations, if any: _____</p>		
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	OTHER TYPES OF RECORDS THAT MAY BE OBTAINED:
CLINIC: _____	RADIOLOGY FILMS: Radiology Film Library 615-322-6311 1211 22 nd 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.