VANDERBILT UNIVERSITY
MEDICAL CENTER

Patient Label or Patient Identifiers

Authorization for Release of Medical Information to VUMC

Authorization (P) - *Release of Medical Information*

PATIENT IDENTIFICATION	Name: _____ Date of Birth: _____ Address: _____ City: _____ State: _____ Zip: _____ Previous Name: _____ Patient Phone: _____

RELEASE RECORDS TO: Vanderbilt University Medical Center

☐ Mail ☐ Pick up in person ☐ Fax ☐ Electronic	Provider Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone #: _____ Fax#: _____

RELEASE RECORDS FROM:

Provider Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone #: _____ Fax#: _____

INFORMATION REQUESTED:

DATES OF TREATMENT TO BE RELEASED

Dates from : _____ to _____ Or specific date: _____

☐ Abstract
☐ Legal medical record

OR Specific Categories

☐ History and physical
☐ Discharge summaries
☐ Operative/procedure notes
☐ Consultations
☐ Radiology reports
☐ Cardiac reports
☐ Pathology reports
☐ Lab results
☐ Emergency services
☐ Obstetrics (labor and delivery)
☐ Office/clinic notes
☐ Respiratory reports
☐ Circle One: FMLA, Power of Attorney, Pre-Admission Screening & Resident Review

☐ Other (*specify*): _____

ADDITIONAL REQUESTS	The information to be released will cover the time period from: _____ to _____ Specific Date: _____ ☐ Cardiac Images (e.g., Cath/ECHO/EKG – *specify*): _____ ☐ Radiology Images (specify): _____ ☐ Billing ☐ Payment Records ☐ Fetal Monitoring Strips ☐ Pharmacy ☐ Home Care Services

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PURPOSE OF RELEASE	☐ Patient Care ☐ Appointment/Sharing with other health care provider as needed ☐ Personal Use ☐ Disability/Insurance Application/Claim ☐ Administrative (i.e., FMLA) ☐ Attorney/Legal Case ☐ Other *(specify):* _____

Authorization for Release of Medical Information

I understand that my medical record may include information on diagnosis or treatment related to psychiatric or psychological conditions, drug or alcohol abuse, and acquired immune deficiency syndrome (AIDS) or HIV status. I agree that any information about such diagnosis or treatment may be released.

PLEASE CHECK THE STATEMENT BELOW THAT APPLIES

(You must check one): I do _____ do not _____ authorize this information to be released.

I would like to limit the information to: _____

I understand that:

- I may refuse to sign this authorization.
- Refusing to sign this authorization will not affect my treatment, payment, enrollment, or eligibility for benefits.
- I may take back (revoke) this authorization in writing, except for any actions already taken based upon it.
- I understand that this authorization will expire when the records are released for the request dated below. Any requests after this date will need a separate authorization.
- If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy rules and may be shared with others.
- I get a copy of this form after I sign it.

Printed Name of Patient/Legal Representative: _____

Signature of Patient/Legal Representative: _____ **Date:** _____ **Time:** _____

Relationship to Patient: _____