Vanderbilt University Medical Center

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO VUMC

(VANDERBILT UNIVERSITY MEDICAL CENTER)

PATIENT IDENTIFICATION	Name:________ Date of Birth________ S.S.#________ Maiden/Other names known by:
RELEASE RECORDS TO: **(Physician or Facility to which records should be sent)** **phone:** (615) 322-2427 **Fax:** (615) 343-0047	**Vanderbilt Medical Center** Name: Student Health Center Address: Zerfoss Building, Station 17 City/State/Zip: Nashville, TN 37232-8710
PROVIDER **(Who is releasing the information)**	Name:________ Address:________ Phone:________ City/State/Zip________ Fax:________
DATES OF TREATMENT	Dates:________

INFORMATION TO BE SENT:

LAB/PATHOLOGY	**CLINIC NOTES**
H&P	**PT,OT, SLT**
DISCHARGE SUMMARY	**OP REPORT**
X-RAY, CT	**OTHER**

PURPOSE OF RELEASE	❑ Medical Care ❑ Insurance ❑ At the request of the patient ❑ Other, Please Explain:________

I understand that I may refuse to sign this authorization, and that my refusal to sign will not affect my ability to obtain treatment. I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance of this authorization.

I understand that the information released may be subject to re-disclosure by some recipients and may no longer be protected by federal and state privacy rules related to health information.

This authorization expires:________(if blank, then 90 days after date of signature)

To revoke this authorization, please send a written request to the provider listed above.

Signature of Patient/Legal Representative:________ Date:________

Relationship to Patient:________