

Vanderbilt Health
Authorization for the Use or Disclosure of
Protected Health Information

Authorization (P) – Release of Medical Information



Patient Label or Patient Identifiers

1. Patient Name

Last Name		First Name		MI	Maiden or Other Name
Date of Birth	Former Name		Medical Record #	Last 4 SSN	
Address			City	State	Zip
Phone Number			Email Address @		

2. I allow the following Vanderbilt health entity to release information

- Vanderbilt University Hospital
 Vanderbilt Psychiatric Hospital
 Vanderbilt Bedford Hospital
 Vanderbilt Behavioral Health Clinics
 Vanderbilt Wilson County Hospital
 Vanderbilt Tullahoma-Harton Hospital
 Vanderbilt Clarksville Hospital
 Vanderbilt Home Care Services
 Monroe Carell Jr. Children's Hospital at Vanderbilt

Vanderbilt Health Clinic/Doctor Name:			Phone:		
Address		City	State	Zip	

3. Send my Protected Health Information to:

Name:		Relationship to Patient:			
Address		City	State	Zip	
Phone:		Fax Option for Physician/Treatment Only:			

4. How I want my Protected Health Information delivered (please select one):

<input type="checkbox"/> Mail (Records will be sent to address above)	<input type="checkbox"/> Electronic (View, print, or download as PDF through request portal. Directions sent to email address above.)	<input type="checkbox"/> Other (Please specify)
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5. Dates and Information to be released: I understand that my protected health information may include information on diagnosis or treatment related to psychiatric or psychological conditions, substance use disorder and acquired immune deficiency syndrome (AIDS) or HIV status. I agree that any information about such diagnosis or treatment will be released unless I check the box below:

- I do not authorize this information to be released.

6. Dates and Information to be released:

Date(s) of Treatment: FROM _____ TO _____

- | | | | | |
|---|---|--|--|--|
| <input type="checkbox"/> Abstract | <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Office Notes | <input type="checkbox"/> Obstetrics (Labor/Delivery) | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Emergency Records | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Medication Records | <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Billing Records |
| <input type="checkbox"/> Immunization Records | <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Inpatient Visit | <input type="checkbox"/> History & Physical | |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Cardiac Reports | <input type="checkbox"/> Images (specify): _____ | | |
| <input type="checkbox"/> Home Health Records | <input type="checkbox"/> Other (specify): _____ | | | |

I also understand that if I do not specify the records I want, the Center for Health Information Management department will send an Abstract of my legal medical record.

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7. If not for your personal use, please tell us reason for request:

Healthcare/Treatment Legal (specify): _____ Other (specify): _____

8. Acknowledgement of Understanding:

- By signing this authorization form, I hereby give Vanderbilt Health permission to disclose my individually identifiable protected health information as described above. I understand this authorization is voluntary.
- Vanderbilt Health recognizes a patient's right under HIPAA to access copies of their protected health information. I understand Federal and State laws allow a fee to be charged. I understand I will be responsible for the payment fees for the cost of preparation, supplies to produce, and the distribution of the disclosure.
- I understand that this authorization will expire when the records are released for the requested dated below. Any requests after this date will need a new authorization.
- I understand that I may cancel this authorization at any time by notifying the providing organization in writing. It will be effective on the date notified except to the extent Vanderbilt Health has already released records based on this authorization.
- I understand once my health information is disclosed as requested, it may no longer be protected by Federal or State privacy regulations/laws. I understand the disclosed records could be redisclosed by the person(s) receiving it.
- By authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care.
- I understand that, if I ask, I will get a copy of this form after I sign it.
- I understand my request will be acted upon within 30 days. If I am not provided access or information cannot be supplied, I understand I will be notified, and have the right to request review of any denial of access other than those made in accordance with applicable law.
- I understand that receiving paper records by mail is not secure, and that my mail could be intercepted and seen by others.
- I understand that a CD/DVD is password protected. The password will be provided or delivered by mail separate from the CD/DVD. I understand that it is my responsibility to protect the data on the device.
- I acknowledge and understand the terms of this Authorization for the Use and Disclosure of Protected Health Information.

9. *If you are NOT the patient but are signing on behalf of the patient, please complete below.***

I understand I MUST attach proof of authority to act on behalf of the patient. Although Parent with Parental Rights may not be required to attach proof of authority, Vanderbilt Health may require proof of parental rights in some custodial situations.

I am the patient's (check one):

- Parent with Parental Rights*
 Legally Designated Healthcare Agent* Court Appointed Guardian or Conservator* Surrogate Decision Maker*
 Court Appointed Personal Representative of Deceased Power of Attorney for Healthcare Decisions/Medical Power of Attorney*
 Power of Attorney with Right to See Medical Records* Other *: _____

****Access to certain behavioral health and substance use disorder records may require additional authorization in accordance with state and federal laws.***

Patient/Legal Representative Print Name: _____

Patient/Legal Representative Signature: _____

Relation: _____ Date: _____ Time: _____

Address: _____ City: _____ State: _____ Zip: _____