



VUMR# \_\_\_\_\_

### Request for Medical Information & Release Authorization

We have been informed that \_\_\_\_\_ has been treated by your office and/or institution.

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ *patient name* Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Name and Address of hospital and/or physician information is being requested from

Name of Physician and/or Institution: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone # ( \_\_\_\_\_ ) \_\_\_\_\_ Fax #: ( \_\_\_\_\_ ) \_\_\_\_\_

We would like to obtain the following information:

- Discharge Summaries
- Educational Records
- History/Physical Examinations
- Laboratory Data
- Psychological Evaluations
- Social Histories
- Recent physical exam results
- Immunization records
- Lab result (Specify) \_\_\_\_\_
- Most recent pap smear results
- Other (Specify) \_\_\_\_\_

Please send or fax the information requested to:  
 Vanderbilt Student Health Center  
 Zerfoss Building, Station 17  
 Nashville, TN 37232-8710  
 Phone: (615) 322-2427  
 Fax: (615) 343-0047  
**Attention:** \_\_\_\_\_

#### Patient Information and Release of Information Authorization

**Purpose of Release** \_\_\_\_\_ Medical Care \_\_\_\_\_ Insurance \_\_\_\_\_ Patient request  
 \_\_\_\_\_ Other, Please explain: \_\_\_\_\_

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, and/or HIV status.** I understand and agree that the information, if any, pertaining to any such diagnosis/treatment described above may be released.

**PLEASE INITIAL THE STATEMENT THAT APPLIES** (You must initial one) I do \_\_\_\_\_ do not \_\_\_\_\_ authorize this information to be released.  
**Limitations, if any:** \_\_\_\_\_

**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: \_\_\_\_\_

**YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:**  
**Right to Inspect or Copy the Health Information to be Used or Disclosed** – I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the Office Manager. **Right to Refuse to Sign this Authorization** - I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. **Right to Revoke This Authorization** – I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization I may contact the Office Manager. I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have already made in reference to this authorization.

**Signature of Patient/Legal Representative:** \_\_\_\_\_

**Witness Signature:** \_\_\_\_\_

**Today's Date:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_