



Request for Medical Information & Release Authorization

VUMR# _____

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, Treatment Plans, 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. 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 use my decision to sign this authorization as a condition for treatment, payment, enrollment in a health plan or eligibility for health care benefits. Right to Revoke This Authorization - I understand written notification is necessary to cancel this authorization.

Signature of Patient/Legal Representative: _____ Date: ____ / ____ / ____

Witness Signature: _____

Patient/Legal Representative Current Phone #:(____) _____