



# Authorization for Release of Information

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

I \_\_\_\_\_, hereby give permission to Vanderbilt University Medical Center and/or an attending physician to release information from my medical records to:

Name and Address of hospital and/or physician information is being released to

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

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

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

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

## 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.

Patient Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Patient Phone #: ( ) \_\_\_\_\_ Home Cell Work

