Vanderbilt University Medical Center

Medical record #_____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

☐ **PATIENT IDENTIFICATION:** Name:_____

Patient Phone#_____ Date of Birth_____ S.S.#_____

PROVIDER: (Who is releasing information)

☐ **RELEASE RECORDS TO:** Name: West End Women's Health Center

(Person or Place records should be sent)

Address: 2611 West End Ave. Suite 380

Phone#: 615-936-5858

City: Nashville

Fax#: 615-936-2600

State/Zip Tennessee 37203

☐ **DATES OF TREATMENT:** Dates:_____

☐ **INFORMATION REQUESTED:**

- ❑ HOSPITAL STAY
- ❑ EMERGENCY ROOM
- ❑ OBSTETRICS and (LABOR and DELIVERY)
- ❑ PSYCHIATRIC HOSPITAL OR CLINICS
- ❑ CLINIC:
- ❑ **OTHER (specify):**

☐ **PURPOSE OF RELEASE:**

❑ Medical Care ❑ Insurance ❑ At the request of the patient

❑ 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 (AIDS), and/or HIV status**.

☐ **PLEASE INITIAL THE STATEMENT THAT APPLIES**
(You must initial one)

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

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_____

Signature of Patient/Legal Representative:_____Date:_____

Relationship to Patient:_____

OTHER TYPES OF RECORDS THAT MAY BE OBTAINED:	
HOME CARE SERVICES: 615-936-0336 2120 Bell Court Avenue Nashville, TN 37212	**RADIOLOGY FILMS:** **Radiology Film Library** **615-322-6311** **1211 22nd Avenue South** **1098 VUH** **Nashville, TN 37232-2675**
PHARMACY (Outpatient) 615-322-6480 **1301 22nd Ave. S.** Nashville, TN 37232-5611	**FINANCIAL OR BILLING RECORDS:** **Patient Accounting Offices** **615-936-0910** **2135 Blakemore - 37212** **Nashville, TN 37212-3505**

How to REVOKE your Authorization for Release of Medical Information

You have the right to revoke your Authorization for Release of Medical Information. To do so you must send us a written letter revoking your authorization. The letter should be mailed to the following address:

Vanderbilt University Medical Center
Medical Information Services- Release of Information
1211 22nd Avenue South
Nashville, TN 37232-7350

If you have any questions please call our Release of Information department at 615-322-2062

Exceptions: This authorization may be revoked except to the extent that:

1. VUMC has taken action in reliance thereon: or
2. If the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim under the policy or the policy itself.

PLEASE NOTE:

When your Medical information is released pursuant to a valid authorization you should be aware of the following:

That the information released may be subject to re-disclosure by the recipient and may no longer be protected by the Privacy Rule.

TREATMENT MAY NOT be withheld, or conditioned on obtaining this authorization.

VANDERBILT UNIVERSITY MEDICAL CENTER
1211 22nd Avenue South, B-334 VUH
Nashville, TN 37232

contracts with HealthPort to process requests for copies of medical records. The release of patient medical information is governed under Federal and Tennessee state statutes.

The following must be presented:

- A completed authorization (all sections of the authorization must be completed for records to be released)

What we will provide at no cost to you:

- Records to your physician for continuing care. Pertinent information (abstract) for continuing care includes transcribed reports (discharge summary, history and physical, operative reports, consultations, ER Notes), radiology reports, lab reports and clinic notes (if applicable). If you would like additional records sent, please specify on the authorization what records are to be sent.

Requests for records to be sent to a third party (attorney, insurance company) can only be completed with a request and authorization directly from that party. If you desire records for this purpose or for your own personal use, the records will be mailed to you and the following fees will apply based on Tennessee Code Annotated 68-11-304(a)(2). If you believe the records you are requesting may exceed a certain dollar amount and would like to be notified of this in advance, please indicate in the area below.

$ .85 per page for pages 1-50
.60 per page for pages 51-250
.35 per page for pages 250 +
+ applicable tax and postage cost

Please notify me if the cost of my records exceeds $_____.

By my signature below, I acknowledge that I am aware of the fee for copies of medical records. I agree to pay this fee when I receive an invoice from ***HealthPort.***

PLEASE PRINT:

NAME:_____ PHONE #:(____)_____

ADDRESS:_____
Street City State Zip

SIGNATURE:_____ DATE:_____