VANDERBILT UNIVERSITY
MEDICAL CENTER

Authorization for Release of Medical Information to VUMC

Administrative>Authorization>Release of Medical Information

PATIENT IDENTIFICATION	Name: _____ Date of Birth:_____ Address:_____ City:_____ State:_____ Zip:_____ Previous Name:_____ Patient Phone:_____

RELEASE RECORDS TO: Vanderbilt University Medical Center

Note: Please indicate Provider
Please indicate location preference.

☐ Mail
☐ Pick up in person
☐ Fax

Provider Name: Dr. Neil Price -or- Dr. Mark Miller
Address: VUMC-GI Department
City: _____ State: TN Zip: 37232
Phone#: 615-322-0128 Fax#: — Nashville 615-322-1951
— Lebanon 615-443-7952

RELEASE RECORDS FROM: Note: Please indicate Provider

Provider Name: Dr. Neil Price -or- Dr. Mark Miller
Address: GastroIntestinal Health Partners
City: Nashville or Lebanon State: TN Zip: _____
Phone#: 615-649-9940 Fax#: 1-877-759-6609

INFORMATION REQUESTED:

DATES OF TREATMENT TO BE RELEASED

Dates from : 04/01/2017 to 12/1/2020 Or specific date: _____

☐ Abstract
☒ Legal medical record

OR Specific Categories

☐ History and physical
☐ Discharge summaries
☐ Operative/procedure notes
☐ Consultations
☐ Radiology reports
☐ Cardiac reports
☐ Pathology reports
☐ Lab results
☐ Emergency services
☐ Obstetrics (labor and delivery)
☐ Office/clinic notes
☐ Respiratory reports
☐ Circle One: FMLA, Power of Attorney, Pre-Admission Screening & Resident Review

☐ Other (*specify*): _____

ADDITIONAL REQUESTS

The information to be released will cover the time period from: _____ to _____ Specific Date: _____
☐ Cardiac Images (e.g., Cath/ECHO/EKG – *specify*): _____
☐ Radiology Images (specify): _____
☐ Billing ☐ Payment Records ☐ Fetal Monitoring Strips ☐ Pharmacy ☐ Home Care Services

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PURPOSE OF RELEASE	☒ Patient Care ☐ Appointment/Sharing with other health care provider as needed ☐ Personal Use ☐ Disability/Insurance Application/Claim ☐ Administrative (i.e., FMLA) ☐ Attorney/Legal Case ☐ Other *(specify):* _____

Authorization for Release of Medical Information

I understand that my medical record may include information on diagnosis or treatment related to psychiatric or psychological conditions, drug or alcohol abuse, and acquired immune deficiency syndrome (AIDS) or HIV status. I agree that any information about such diagnosis or treatment may be released.

PLEASE CHECK THE STATEMENT BELOW THAT APPLIES

(You must check one): I do _____ do not _____ authorize this information to be released.

I would like to limit the information to: _____

I understand that:

- I may refuse to sign this authorization.
- Refusing to sign this authorization will not affect my treatment, payment, enrollment, or eligibility for benefits.
- I may take back (revoke) this authorization in writing, except for any actions already taken based upon it.
- I understand that this authorization will expire when the records are released for the request dated below. Any requests after this date will need a separate authorization.
- If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy rules and may be shared with others.
- I get a copy of this form after I sign it.

Printed Name of Patient/Legal Representative: _____

Signature of Patient/Legal Representative: _____ **Date:** _____ **Time:** _____

Relationship to Patient: _____