Vanderbilt Health

Authorization for the Use or Disclosure of Protected Health Information

Authorization (P) – *Release of Medical Information*

Patient Label or Patient Identifiers

1. Patient Name

Last Name	First Name	MI	Maiden or Other Name
Date of Birth	Former Name	Medical Record #	Last 4 SSN
Address	City	State	Zip
Phone Number	Email Address @		

2. I allow the following Vanderbilt health entity to release information

☐ Vanderbilt University Hospital ☐ Vanderbilt Psychiatric Hospital ☐ Vanderbilt Bedford Hospital

☐ Vanderbilt Behavioral Health Clinics ☐ Vanderbilt Wilson County Hospital ☐ Vanderbilt Tullahoma-Harton Hospital

☐ Monroe Carell Jr. Children's Hospital at Vanderbilt ☐ Vanderbilt Home Care Services

Vanderbilt Health Clinic/Doctor Name:	Phone:		
Address	City	State	Zip

3. Send my Protected Health Information to:

Name:	Relationship to Patient:		
Address	City	State	Zip
Phone:	Fax Option for Physician/Treatment Only:		

4. How I want my Protected Health Information delivered (*please select one*):

☐ **Mail** (Records will be sent to address above)	☐ **Electronic** (View, print, or download as PDF through request portal. Directions sent to email address above.)	☐ **Other** (Please specify)

5. Reasonable fees for records listed below. Postage will be added for mailed records.

Type of Request	How Record is Stored	How Record is Delivered	Production Fees	Paper Fee	Max Fees
Electronic	Electronic	Electronic	$6.50 flat fee	None	None
Electronic	Paper	Electronic	0.7¢ per page	None	$50 max
Electronic	Paper	Electronic & Paper	$6.50 flat fee	0.7¢ per page	$50 max
Paper	Paper	Paper	0.7¢ per page	0.5¢ per page	$50 max
Paper	Electronic	Paper	0.90¢ flat fee	0.5¢ per page	$50 max
Paper	Paper	Electronic & Paper	0.90¢ flat fee	0.7¢ per page	$50 max

6. Dates and Information to be released: I understand that my protected health information may include information on diagnosis or treatment related to psychiatric or psychological conditions, substance use disorder, and acquired immune deficiency syndrome (AIDS) or HIV status. I agree that any information about such diagnosis or treatment will be released unless I check the box below:

☐ I do not authorize this information to be released.

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7. Dates and Information to be released:

Date(s) of Treatment: FROM _____ **TO** _____

☐ Abstract	☐ Lab Reports	☐ Office Notes	☐ Obstetrics (Labor/Delivery)	☐ Discharge Summary
☐ Emergency Records	☐ Radiology Reports	☐ Medication Records	☐ Operative Reports	☐ Billing Records
☐ Immunization Records	☐ Pathology Reports	☐ Inpatient Visit	☐ History & Physical	
☐ Progress Notes	☐ Cardiac Reports	☐ **Images (specify):** _____		
☐ Home Health Records		☐ **Other (specify):** _____		

I also understand that if I do not specify the records I want, the Center for Health Information Management department will send an Abstract of my legal medical record.

8. If not for your personal use, please tell us reason for request:

☐ Healthcare/Treatment ☐ Legal (specify): _____ ☐ Other (specify): _____

9. Acknowledgement of Understanding:

- By signing this authorization form, I hereby give Vanderbilt Health permission to disclose my individually identifiable protected health information as described above. I understand this authorization is voluntary.
- Vanderbilt Health recognizes a patient's right under HIPAA to access copies of their protected health information. I understand Federal and State laws allow a fee to be charged. I understand I will be responsible for the payment fees for the cost of preparation, supplies to produce, and the distribution of the disclosure.
- I understand that this authorization will expire when the records are released for the requested dated below. Any requests after this date will need a new authorization.
- I understand that I may cancel this authorization at any time by notifying the providing organization in writing. It will be effective on the date notified except to the extent Vanderbilt Health has already released records based on this authorization.
- I understand once my health information is disclosed as requested, it may no longer be protected by Federal or State privacy regulations/laws. I understand the disclosed records could be redisclosed by the person(s) receiving it.
- By authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care.
- I understand that, if I ask, I will get a copy of this form after I sign it.
- I understand my request will be acted upon within 30 days. If I am not provided access or information cannot be supplied, I understand I will be notified, and have the right to request review of any denial of access other than those made in accordance with applicable law.
- I understand that receiving paper records by mail is not secure, and that my mail could be intercepted and seen by others.
- I understand that a CD/DVD is password protected. The password will be provided or delivered by mail separate from the CD/DVD. I understand that it is my responsibility to protect the data on the device.
- I acknowledge and understand the terms of this **Authorization for the Use and Disclosure of Protected Health Information.**

10. ***If you are NOT the patient but are signing on behalf of the patient, please complete below.*

I understand I MUST attach proof of authority to act on behalf of the patient. Although Parent with Parental Rights may not be required to attach proof of authority, Vanderbilt Health may require proof of parental rights in some custodial situations.

I am the patient's (check one): ☐ Parent with Parental Rights*

☐ Legally Designated Healthcare Agent* ☐ Court Appointed Guardian or Conservator* ☐ Surrogate Decision Maker*

☐ Court Appointed Personal Representative of Deceased ☐ Power of Attorney for Healthcare Decisions/Medical Power of Attorney*

☐ Power of Attorney with Right to See Medical Records* ☐ Other *: _____

Access to certain behavioral health and substance use disorder records may require additional authorization in accordance with state and federal laws.

Patient/Legal Representative Print Name: _____

Patient/Legal Representative Signature: _____

Relation: _____ Date: _____ Time: _____

Address: _____ City: _____ State: _____ Zip: _____