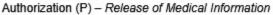
## Vanderbilt Health Authorization for the Use or Disclosure of Protected Health Information





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Last Name		First Name			MI	Maid	len or Other Nam
Date of Birth Former Name		ame	Medical Record #			Last 4 SSN	
Address			City		State	Zip	
Phone Number			Email Address		@		
low the follow	ing Vanderbilt hea	Ith entity to relea	ase information				
☐ Vanderbilt U	Iniversity Adult Hospita	al □ Vando	erbilt Psychiatric Hosp	oital 🗆	Vanderbilt	Bedford	Hospital
	ehavioral Health Clinic		erbilt Wilson County H				na-Harton Hospita
п.,			•				•
	ell Jr. Children's Hospi				/034-3-10-		
Vanderbilt Heal	th Clinic/Doctor Name				Phone:		
Address			City			State	Zip
d my Protecte	d Health Information	on to:	1				
Name:				Relations	hip to Patie	ent:	
			City			State	Zip
Address			l l				
Phone:			Fax Option for Phy	ysician/Treatme	ent Only:		
Phone:	rotected Health Inf	ormation deliver	<u> </u>		ent Only:		
Phone:	rotected Health Inf	ormation deliver	<u> </u>		ent Only:		
Phone:		ormation deliver	red (please select		35%	ier (Plea	se 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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## Vanderbilt Health Authorization for the Use or Disclosure of Pr

Address:

		dical Information				
7.	Dates and Information	to be released:				
	Date(s) of Treatment: FR	ОМ	то	12 AS		
	□ Abstract □ Emergency Records □ Immunization Records □ Progress Notes	□ Lab Reports □ Radiology Reports □ Pathology Reports □ Cardiac Reports	☐ Office Notes ☐ Medication Records ☐ Inpatient Visit ☐ Images (specify): ☐ Other (specify):	☐ Ope		☐ Billing Records
	I also understand that if I do Abstract of my legal medica		I want, the Center for Hea	alth Inforr	nation Management d	lepartment will send an
8.	If not for your personal	use, please tell us r		_ 🗆 Ot	her (specify):	
	Healthcare/Treatment Legal (specify): Other (specify): Other (specify): Psy signing this authorization form, I hereby give Vanderbilt Health permission to disclose my individually identifiable protection 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 understate 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 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 effect 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 privace 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 it will be notified, and have the right to request review of any denial of access other than those made in accordar 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 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 protect					
l am	the patient's (check one):	□ Parent with	Parental Rights*			
*Ac	□ Legally Designated Hea □ Court Appointed Person □ Power of Attorney with I	nal Representative of Dec Right to See Medical Re	cords*	orney for	Healthcare Decisions	80,05 x0 50,05
with	state and federal laws.			3 4		
	nt/Legal Representative					
	nt/Legal Representative					

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