VANDERBILT UNIVERSITY
MEDICAL CENTER

Authorization for Release of Medical Information: Billing & Fees

Vanderbilt University Medical Center
Medical Information Services • 4560 Trousdale Drive, Suite 101, Nashville, TN 37204

Vanderbilt University Medical Center contracts with HealthPort to process requests for copies of medical records. The release of patient medical information is governed under federal and state laws.

To release your medical information from Vanderbilt University Medical Center, you must:

- Complete all sections of the Authorization for Release of Medical Information form.
- Hand-deliver, mail, or fax a signed request in writing to VUMC, Attn: Release of Information.
- If you are under the age of 18, your parent or legal guardian must sign as well.

What we will provide to the patient at no cost (For patient Walk-in requests only).
At no cost to you, we will provide up to 50 pages of the medical records that are relevant to your care. This is called an **abstract**. If you want additional records, you will need to specify which ones on Page 1.

What is an abstract?
An abstract contains only the medical records needed by you and your providers to continue your care after discharge. This is what is released unless you ask for your **legal medical record**. (The abstract usually includes: Discharge Summary, History & Physical, Lab, Pathology, Operative Reports, Procedure Notes, Radiology Reports, Problem List and Medications).

What is a legal medical record?
In addition to what is in the abstract, your legal medical record has all the information needed to identify you, support your diagnosis, justify your treatment, and document your care and results.

What we will provide for a reasonable fee
If you want your records sent to someone other than your doctor or for your own personal use, you must complete and sign an authorization. Also, you or the person receiving the records must agree to pay the fees. Here are the fees, based on Tennessee Code Annotated 68-11-304(a)(2):

$0.85 per page for 1 to 50 page.
$0.60 per page for 51 to 250 pages
Plus postage and any taxes that may apply
$0.35 per page for over 250 pages
$0.50 per electronic photograph

If you would like to know in advance if the fee will be more than a certain amount, indicate this here:
Let me know if the fee for my records will be more than $_____.

I understand that there may be fees for copying my medical records. By signing below, I agree to pay these fees when I am billed for them by HealthPort**.**

Name: _____ Phone: (____) _____

Address: _____
Street City State Zip

Signature: _____ Date: _____

Authorization for Release of Medical Information

Please contact the following departments directly, if your request for information is related to *home care services, radiology/imaging services, pharmacy services,* or *financial records.*	
HOME CARE SERVICES: 2120 Belcourt Avenue Nashville, TN 37212 (615) 936-0336	**RADIOLOGY IMAGES (X-Rays):** Medical Imaging Library 1301 Medical Center Drive TVC 1631 Nashville, TN 37232-2675 Phone: 615-322-0866 Fax: 615-343-6373
PHARMACY (Outpatient): 1301 22nd Ave. S. Nashville, TN 37232-5611 (615) 322-6480	**FINANCIAL OR BILLING RECORDS:** Patient Accounting One Hundred Oaks 719 Thompson Lane, Ste 30140 Nashville, TN 37204 (615) 936-0910 or (866) 488-4677

How to Take Back (Revoke) your Authorization for Release of Medical Information

You have the right to take back (revoke) your authorization to release of your medical records. To do this you must put your request in writing and mail it to:

Vanderbilt University Medical Center
Medical Information Services
Attn: Release of Information
4560 Trousdale Drive
Suite 101
Nashville, TN 37204-4538

If you have any questions please call the Release of Information Department at 615-322-2062.

Revoking this authorization will not affect any actions that Vanderbilt University Medical Center may have already taken based on the authorization.

Also, if the authorization was a condition for getting insurance, revoking it does not affect the insurer's right to contest a claim made under the policy, or the policy itself.

When you release your medical information, whoever receives it may share it (except for any notes about drug or alcohol use and psychotherapy notes) with someone else. In this case, the information may no longer be protected by the HIPAA/Privacy Rule.

Treatment cannot be withheld or based on getting this authorization.

VANDERBILT UNIVERSITY MEDICAL CENTER

Medical Record #_____
FOR STAFF USE ONLY

Medical Information Services
Authorization for Release of Medical Information

administrative>authorization>release of medical information

Please complete all pages of this form, sign, and return to:

☐ **Vanderbilt University Medical Center • Medical Information Services • Attn: Release of Information • 4560 Trousdale Drive • Suite 101 • Nashville, TN 37204-4538. Or submit by fax to (615) 343-0126. Contact our office at (615) 322-2062 with questions.**

☐ **Vanderbilt Psychiatric Hospital • Medical Information Services • Attn: Release of Information • 1601 23rd Ave. South Nashville, TN 37212. Or submit by fax to (615) 327-7158. Contact our office at (615) 327-7153 with questions.**

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

I request and authorize Vanderbilt University Medical Center to release medical information of the patient named above.

RELEASE RECORDS TO: (Where records should be sent)

☐ Mail
☐ Pick up in person
☐ Fax
☐ Electronic

☐ ***Same as above***
Name/Agency: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone#: _____ Fax#: _____
E-mail Address: _____ (For Doctors or other HealthCare Providers Only)

INFORMATION REQUESTED: Fees may apply. See Billing & Fees.

Is this request for psychotherapy notes? ☐ If yes, this is the only item you may request on this authorization. You must submit a separate authorization for any items below. ☐ If no, you may check any items below.

MEDICAL RECORD INCLUDES RECORDS FROM:

- Vanderbilt University Hospital
- Monroe Carell Jr. Children's Hospital at Vanderbilt
- Vanderbilt Psychiatric Hospital
- Vanderbilt Medical Group

DATES OF TREATMENT TO BE RELEASED

Dates from : _____ to _____ Or specific date: _____

☐ Abstract (see definition on page 1)
☐ Legal medical record (see definition on page 1)

OR Specific Categories

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

OTHER DEPARTMENT

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

Medical Record #_____

FOR STAFF USE ONLY

PURPOSE OF RELEASE	☐ Patient Care ☐ Personal Use ☐ Administrative (i.e., FMLA)	☐ Appointment/Sharing with other health care provider as needed ☐ Disability/Insurance Application/Claim ☐ 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.

I also understand that if I do not ask for my legal medical record or specify the records I want, the Medical Information Services department will send an abstract of my legal medical record.

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: _____