VANDERBILT IMAGING SERVICES
AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Information:

Name:_____

Date of Birth:_____ S.S#:_____

Exam or Dates of Service Requested:

Exam(s) Requested:_____
Exam Date(s):_____

Release Records To: (Person or Place records should be sent or released to)

Name:_____

Address:_____

City, State, Zip:_____

Fax Number:_____

Information Requested From:

☐ **Vanderbilt Imaging Services, LLC.**
dbd-Hillsboro Imaging
1909 Acklen Ave
Nashville, TN. 37212
P: 615-777-9729
F: 615-777-9733

☐ **Williamson Imaging Services, LLC.**
dba-Cool Springs Imaging
2009 Mallory Lane, Ste. 150
Franklin, TN. 37064
P: 615-771-8668
F: 615-771-9298

☐ **Vanderbilt Imaging Belle Meade**
4525 Harding Road, Ste. 102
Nashville, TN. 37205
P: 615-463-3034
F: 615-463-3187

☐ **One Hundred Oakes Imaging**
719 Thompson Lane, Ste 23300
Nashville, TN. 37204
P: 615-936-3606
F: 936-5343

Purpose for release:

☐ Medical Care ☐ Insurance ☐ At the request of the patient ☐ Other:_____

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

PLEASE INITIAL THE STATEMENT THAT APPLIES:

_____ I **do** authorize this information to be released _____ I **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 or Legal Gaurdian:_____ **Date:**_____

Relationship to Patient:_____

THERE MAY BE A CHARGE FOR COPIES OF YOUR MEDICAL RECORD UNLESS THE COPIES ARE BEING SENT TO ANOTHER PHYSICIAN OR HEALTHCARE FACILITY