VANDERBILT UNIVERSITY
MEDICAL CENTER

# Authorization to Access Medical Records

**PATIENT IDENTIFICATION**

Name: _____

Date of Birth_____

Medical record #_____

***(Signed original will be placed in the paper medical record and/or StarPanel and a copy will be provided to the patient)***

*Please list any family members or others who you give permission to view the information found in your medical record.

| NAME: | STAR USER ID: | RELATIONSHIP TO PATIENT | EXPIRATION DATE: |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

*I understand that my medical record may include a wide variety of inpatient and outpatient information on diagnosis, treatment, and procedures including psychiatric or psychological conditions, drug and/or alcohol abuse, acquired immune deficiency syndrome (AIDS), and HIV status.

**We will continue to rely on the information on this form unless you request changes. It is your responsibility to immediately notify Medical Information Services of a divorce, legal separation, change in custody arrangement, or any other circumstance, which may alter this authorization.**

**To revoke or alter this authorization, please send a written request with a copy of this form to the address below:**

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

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

**Relationship to Patient: _____**

If you have any questions or need support in accessing the medical record please call VUMC Medical Information Services at (615) 322-2824.

**(If unit or clinic not yet scanning items into the electronic medical record, fax this form to 615-322-5019.)**