



Select communication preference for release:
 Release to Request from Mail Verbal only
 Fax Secure Email Pick up in Person All

CONSENT FOR RELEASE & DISCLOSURE OF INFORMATION
(To facilitate communication in order to coordinate services)

I, _____ DOB _____, do hereby authorize and consent to the release and disclosure of information in the form of written documentation and records as well as verbal releases and disclosures unless otherwise noted above between relevant healthcare providers and staff within the Student Care Network (Student Care Coordination, University Counseling Center, Center for Student Wellbeing, and Student Health Center) and:

Provider/Parent/Organization: _____

Other: _____

Phone: _____ **Fax:** _____ **Email:** _____

Address: _____

Reason For Disclosure: If you do not wish to list the reasons for sharing, select "At my Request."

Patient Care At my request Other (Please detail) _____

What Information Can Be Disclosed? Complete the following by indicating those items that you want disclosed. *If all health information is to be released, then check only the first box.*

- | | | |
|---|---|--|
| <input type="checkbox"/> All health information | <input type="checkbox"/> Past/Present Medications | <input type="checkbox"/> Radiology Reports |
| <input type="checkbox"/> Student Records | <input type="checkbox"/> Lab Results | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Diagnostic Test Reports | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> History/Physical Exam | <input type="checkbox"/> Physician's Orders | _____ |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Consultation Notes/Reports | _____ |

I understand that my record may include information on diagnosis or treatment related to psychiatric or psychological conditions, and drug or alcohol use status.

Restrictions on release of information:

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:

12 months from today Until I am no longer considered a student Other _____

I hereby release Vanderbilt University, Vanderbilt University Medical Center, and their employees, agents, and staff members who may participate in this disclosure from any right or claim that I might otherwise have for damages or other liability which might arise out of or result from disclosures authorized by signing this release. I understand that 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 understand that I have a right to a copy of this release of information. I understand I may refuse to sign this release of information, and my refusal will not affect my ability to obtain services.

 Printed name of student

 Date

 Signature of student