VANDERBILT
Student Affairs
Student Care Network

CONSENT FOR RELEASE 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 disclosures between relevant healthcare providers and staff within the Student Care Network primary offices (Student Care Coordination, University Counseling Center, Center for Student Wellbeing, and Student Health Center) and:

Medical Treatment Provider: _____

Phone/fax: _____ Address: _____

Medical Treatment Provider: _____

Phone/fax: _____ Address: _____

Other: _____

Other: _____

Other: _____

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 the date hereof
- ☐ Upon my departure from Vanderbilt
- ☐ Other: _____

I hereby release Vanderbilt University, Vanderbilt University Medical Center, 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 I have a right to a copy of this release of information.

I understand I may refuse to sign this release of information. My refusal will not affect my ability to obtain services.

_____ _____
Signature of Student Date

_____ _____
Printed Name of Student Date