PRINT RESET

Request from Law Enforcement for Release of Protected Health Information

Patient's Name (if known): _____ **Date:** _____

Requestor's Name:_____ **Requestor's Title:** _____

Agency Name:_____ **Phone Number:** _____

Agency Address: _____

Agency Assigned Number: _____ **(assigned agency case #, warrant #, or related incident report #)**

Requested Information Related to an Active Law Enforcement Investigation:_____

_____

_____

Signature of Requestor/Officer: _____

Please check the appropriate legal exception that will allow the requested information to be released:

☐ **Suspect, Fugitive, Material Witness, or Missing Person**. I certify that the information about the above named patient is needed to assist in attempting to identify or locate a suspect, fugitive, material witness, or missing person. I understand that the information I can obtain is limited under federal law. (45 CFR §§ 164.512(f)(2).)

☐ **Injury by Violence.** The information sought concerns a person suffering from a wound or injury inflicted by means of violence that must be reported to law enforcement under Tennessee law, and is limited to the name, residence and employer of the person, the person's whereabouts, the place the injury occurred, and the character and extent of the injuries.

☐ **Child or Elder Abuse.** The information is sought pursuant to an investigation of suspected child brutality, abuse, neglect or child sexual abuse, or abuse, neglect or exploitation of an adult who is unable to protect themselves without assistance from others because of a mental or physical dysfunction or advanced age (as set forth in TCA §§ 71-6-102 et seq.).

☐ **Victim of a Crime.** The information sought concerns a possible victim of a crime in a situation not otherwise covered by other categories on this form. Either the suspected victim's written agreement to the disclosure is attached to this form, or I request that appropriate personnel seek the victim's agreement to the disclosure. If the victim's agreement cannot be obtained due to incapacity or other emergency circumstance, I certify that the information is needed to determine whether a violation of law by someone other than the victim has occurred, that the information is not intended to be used against the victim, and that the investigation would be materially and adversely affected by waiting until the patient is able to agree to the disclosure. I understand that the disclosure is subject to a determination of what is in the best interests of the patient in the exercise of professional judgment by medical professionals.

☐ **Legal Process**. A court order, judicial subpoena, warrant, summons, grand jury subpoena or other legal process seeking the requested information has been issued and is attached to this form. (45 CFR §§ 164.512(f)(1)(ii)(A) and (B).)

☐ **Crime on Premises.** The information sought constitutes evidence of possible criminal conduct occurring on the premises of Vanderbilt University.

☐ **Patient Authorization.** I have received written authorization from the patient for the release of medical information. A copy of the dated release with patient signature is attached.

☐ **Patient in Custody.** I certify that the above named patient is in lawful custody of the correctional facility or agency listed above, and the requested information is needed for the healthcare of the patient, the safety of the patient, other inmates, officers of the facility or transporting the patient, or for the administration of the safety, security, and order of the facility as allowed under 45 CFR §§ 164.512(k)(5)(i).

☐ **Motor Vehicle Accident Injury or Death.** I certify I have probable cause to believe that the driver of a motor vehicle involved in an accident resulting in the death or injury of another has committed a violation of TCA 55-10-401, 39-13-213(a)(2), or 39-13-218. Therefore, in accordance with TCA 55-10-406, I shall cause the driver to be tested for the purpose of determining the alcohol and/or drug content of such driver's blood.

☐ **Other:** If no category on this form describes your request, please describe here;

_____

_____

_____

VPD IR#:	**VPD OFFICER:**	**VPD OFFICER ID:**
MRN#	**PATIENT NAME:**	**DATE OF BIRTH:**
REQUESTER IDENITY VERIFIED? ☐ Yes ☐ No	**DATE INFORMATION RELEASED:** _____	
INFO RELEASED VIA PHONE (Exigent Circumstance), UNABLE TO OBTAIN SIGNATURE. ☐ Yes ☐ No		
Protected Health Info Released:		