AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

(See back of form for facility locations)

Patient's Name____Date of Birth ________________________

Address____Phone # ________________________

I,____, hereby authorize

FULL NAME OF PATIENT

____ to release information specified below from my

NAME OF HOSPITAL / PHYSICIAN / FACILITY

medical records covering the dates of service_____________________to ______________________

The information which is checked (X) below is to be released to:

____

NAME OF PERSON, HOSPITAL, PHYSICIAN, SERVICE AGENCY OR THIRD PARTY (Provide fax # if hospital or physician)

____

ADDRESS CITY STATE ZIP

Purpose for Release: ☐ Medical ☐ Insurance ☐ Legal ☐ Other ____

***Purpose of Release is not required for patient/personal representative requests.**

Check off items being released:

- ☐ Discharge Summary
- ☐ Discharge Instructions/After Visit Summary
- ☐ History & Physical
- ☐ Consultation Reports
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ Laboratory
- ☐ Cardiology
- ☐ Clinic Visit
- ☐ Abstract
- ☐ Operative Report
- ☐ X-ray Report
- ☐ Radiology films
- ☐ ER Record
- ☐ Entire Record
- ☐ Billing Record

Other _______________________

Method of Delivery: ☐ Paper ☐ Fax # ____________________ ☐ CD ☐ Email ________________________________

The patient's express authorization is required to release certain types of records, including alcohol and/or drug abuse treatment and information, HIV testing and treatment, psychiatric treatment, and genetic testing (defined in the Genetic Information Non-Discrimination Act of 2008 - GINA, section 201 7 A and B). To authorize release of this information, please read and sign the following:

I,________________________________, authorize the release of **alcohol and/or drug abuse** treatment and information.
(Patient's Signature)

I,________________________________, authorize the release of **HIV test results** and/or HIV treatment information.
(Patient's Signature)

I,________________________________, authorize the release of **psychiatric** information.
(Patient's Signature)

I,________________________________, authorize the release of **genetic testing** information.
(Patient's Signature)

In authorizing the release of the confidential information identified above, I hereby waive all restrictions or privileges imposed by law and release Ochsner Health System and its affiliates and their staff from any restriction or privilege imposed by law in connection with the disclosure or release of any professional record, observation or communication. I do understand that the information that is being released may be subject to re-disclosure by the recipient and may no longer be protected. I understand that my treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.

This authorization may be revoked in writing at any time, except to the extent that Ochsner Health System and its affiliates have already taken action in reliance on it. Letters to revoke this authorization should be addressed to Ochsner Medical Center, Release of Information Department, 1201 Dickory Avenue, Harahan, LA 70123.

If not previously revoked in writing, this authorization will terminate or expire upon (state the specific date, event, or condition):

____

If expiration date is left blank, authorization will expire within one year.

____________________________________ ____________________________ __________________
SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE | RELATIONSHIP TO PATIENT | DATE SIGNED

____
ADDRESS | PHONE NUMBER

____________________________________ ____________________________ __________________
SIGNATURE OF WITNESS (if patient is unable to sign) | RELATIONSHIP TO PATIENT OR CREDENTIALS | DATE SIGNED

FOR HIM USE ONLY: Date Rec'd _____Date Processed______Time Frame________Processed By___________# Pages/Amount ______

FACILITY LOCATIONS

ATTN: Release of Information
Ochsner Lafayette General Medical Center/Orthopedic Hospital Service Center
900 E. St. Mary Blvd.
Lafayette, LA 70503
Phone: 337-289-7771
Fax: 337-571-0495

ATTN: Release of Information
Ochsner Abrom Kaplan Memorial Hospital
1310 West 7th St
Kaplan, LA 70548
Phone: 337-643-5301
Fax: 337-643-5039

ATTN: Release of Information
Ochsner Acadia General Hospital
1305 Crowley Rayne Hwy
Crowley, LA 70526
Phone: 337-788-6447
Fax: 337-788-6449

ATTN: Release of Information
Ochsner St Martin Hospital
210 Champagne Blvd
Breaux Bridge, LA 70517
Phone: 337-507-1218
Fax: 337-507-1126

ATTN: Release of Information
Ochsner University and Clinics
2390 West Congress St
Lafayette, LA 70506
Phone:337-261-6191
Fax: 337-261-6205

Health Information Management
Release of Information

Due to the volume of request for copies of medical records received daily, Ochsner Health System contracts MRO (Medical Records Online) to copy and release medical records. For this service, there is a fee mandated by law, however medical information will be forwarded to hospitals and physicians free of charge.

For copies of your records, you may be assessed a fee based on the following fee schedule:

Pages of Records	Format you will receive the records	Reasonable, Cost-Based Fee
1-50 pages	Paper (Picked Up)	No charge
51-and up	Paper (Picked Up)	$6.50 plus tax
Any number of pages	Electronic (Email or CD)	$6.50 plus tax and postage
Any number of pages	Paper (Mailed)	$6.50 plus tax and postage

Once the records are ready, you will be notified via mail. Please review the invoice for payment information. Payment may be made by check, credit card or money order.

Please note, records from another facility contained within the requested records may be released.

Please call 610.994.7500 Ext. 1 to check the status of your request, make a payment or ask any questions about your request.