Ochsner Health System

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

_____
ADDRESS CITY STATE ZIP

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

Check off items being released:

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

Method of Delivery: ☐ Paper ☐ Fax # _____ ☐ Electronic: 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 _____

Ochsner Health System

FACILITY LOCATIONS

Ochsner Medical Center
Ochsner Health Centers
1514 Jefferson Highway
New Orleans, LA 70121
Phone: (504) 842-2832
Fax: (504) 842-4047

Ochsner Baptist
Medical Center
2700 Napoleon Avenue
New Orleans, LA 70115
Phone: (504) 894-2173
Fax: (504) 894-2460

Ochsner Medical Center
Ochsner Health Centers
Baton Rouge
17000 Medical Center Drive
Baton Rouge, LA 70816
Phone: (225) 236-5917
Fax: (225) 236-5469
or (225) 761-5939

Ochsner Kenner
Medical Center
180 West Esplanade Avenue
Kenner, LA 70065
Phone: (504) 464-8066
Fax: (504) 464-8093

Ochsner Medical Center
Ochsner Health Centers
North Shore
100 Medical Center Drive
Slidell, LA 70461
Phone: (985) 646-5009
Fax: (985) 646-5606

Ochsner Medical Complex
River Parishes
502 Rue de Sante
Laplace, Louisiana 70068

Request for medical records for visits ON or AFTER Nov. 1, 2014 contact:
Ochsner Kenner Medical Center
Phone: (504) 464-8066
Fax: (504) 464-8093

Ochsner St. Anne General
4608 Hwy One
Raceland, LA 70394
Phone: (985) 537-8364
Fax: (985) 537-8296

Ochsner Westbank
Medical Center
2500 Belle Chasse Highway
Gretna, LA 70056
Phone: (504) 207-2525
Fax: (504) 391-5115

Leonard J. Chabert
Medical Center
(an affiliate of Ochsner Health System)
1978 Industrial Blvd.
Houma, LA 70363
Phone: (985) 873-2207
Fax: (985) 873-2420

St. Charles Parish Hospital
(an affiliate of Ochsner Health System)
P.O. Box 87
1057 Paul Maillard Road
Luling, LA 70070
Phone: (985) 785-3652
Fax: (985) 785-3739