Ochsner Medical Center
Ochsner Health Centers
1514 Jefferson Highway
New Orleans, LA 70121

Phone: (504) 842-2832 Fax: (504) 842-4047

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

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

_____
ADDRESS CITY STATE ZIP

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

Check off items being released:

- ☐ Discharge Summary
- ☐ Discharge Instructions/After Visit Summary
- ☐ History & Physical
- ☐ Consultation Reports
- ☐ Pathology Reports
- ☐ Laboratory
- ☐ Cardiology
- ☐ Clinic Visit
- ☐ Hospital admission
- ☐ Abstract ( )
- ☐ Other _____
- ☐ Dictated Letter
- ☐ Operative Report
- ☐ X-ray Report
- ☐ ER Record
- ☐ Entire Record

Method of Delivery: ☐ paper ☐ Electronic delivery: Email address _____

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 Medical Center and Ochsner Health Centers and its 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 Medical Center and Ochsner Health Centers have already taken action in reliance on it. Letters to revoke this authorization should be addressed to Ochsner Medical Center, Release of Information Department, 1514 Jefferson Highway, New Orleans, LA, 70121.

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

_____ _____
ADDRESS DATE SIGNED

_____
PHONE NUMBER CORRESPONDENCE

Form No. 20048 (Rev. 10/9/2013)