 I,, authorize the release of alcohol and/or drug abuse treatment and information. I,, authorize the release of HIV test results and/or HIV treatment information. I,, authorize the release of psychiatric information. I,, authorize the release of psychiatric information. I,, authorize the release of genetic testing information. I,, authorize the release of genetic testing information. In authorizing the release of the confidential information identified above, I hereby waive all restrictions or privileges imposed by law and release Ochsner Health Center - Mandeville 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 	Ochsner Health Center - Release of Information De 2810 East Causeway Ap Mandeville, LA 704	partment pproach			
CONFIDENTIAL INFORMATION Patient's Name	Phone: (985) 871-2545	985) 875-2767			
Address					
I,	Patient's Name			Date of Birth.	
I,	Address			Phone #	
Image: CF PATIENT to release information specified below from my Image: CF PASIFIAL (PHYSICIAN) FACILITY to release information specified below from my Image: CF PASIFIAL (PHYSICIAN) FACILITY to release information specified below from my Image: CF PASIFIAL (PHYSICIAN) FACILITY to release information specified below from my Image: CF PASIFIAL (PHYSICIAN) FACILITY to release the release to release the release to release to release to release the release to re					
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The information which is checked (X) below is to be released to: NAME OF HOSPITAL, PHYSICIAN, SERVICE AGENCY OR THIRD PARTY ADDRESS OTY STATE ZIP Purpose for Release: Medical Insurance Legal Other	NAME OF HOSPITAL / PHYSICIA	N / FACILITY	_ to relea	se informatio	n specified below from my
NAME OF HOSPITAL, PHYSICIAN, SERVICE AGENCY OR THIRD PARTY ADDRESS			to)	
ADDRESS CITY STATE ZIP PUrpose for Release: Insurance Legal Other	The information which is checked (X) to	pelow is to be released to	:		
Purpose for Release: Medical Insurance Legal Other Check off items being released: Laboratory Dictated Letter Discharge Summary Cardiology Operative Report Discharge Instructions/After Visit Summary Clinic Visit X-ray Report Consultation Reports Abstract () Entire Record Pathology Reports Other ER Record Method of Delivery: Dapaer 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 ND loscrimination Act of 2008 - GINA, section 201 7 A and B). To authorize release of this information, please read and sign ti following: I, (Patient's Signature) , authorize the release of alcohol and/or drug abuse treatment and information. I, (Patient's Signature) , authorize the release of genetic testing information. I, (Patient's Signature) , authorize the release of genetic testing information. I, (Patient's Signature) , authorize the release of genetic testing information. I, (Patient's Signature) , authorize the release of genetic testing information.	NAME OF HOSPITAL, PHYSICIAN, SERVICE AGENC	Y OR THIRD PARTY			
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The patient's express authorization is required to release certain types of records, including alcohol and/or drug abuse treatment and information, AIV testing and treatment, psychiatric treatment, and genetic testing (defined in the Genetic Information No Discrimination Act of 2008 - GINA, section 201 7 A and B). To authorize release of this information, please read and sign the following: 1,	D Pathology Reports	L Other			
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(Patient's Signature) , authorize the release of genetic testing information. In authorizing the release of the confidential information identified above, I hereby waive all restrictions or privileges imposed by law and release Ochsner Health Center - Mandeville 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 Health Center - Mandeville has already taken action in reliance on it. Letters to revoke this authorization should be addressed to Ochsner Health Center - Mandeville has already taken action in reliance on it. Letters to revoke this authorization should be addressed to Ochsner Health Center - Mandeville has already taken action in reliance on it. Letters to revoke this authorization should be addressed to Ochsner Health Center - Mandeville has already taken action in reliance on it. Letters to revoke this authorization should be addressed to Ochsner Health Center - Mandeville has already taken action in reliance on or condition): If not previously revoked in writing, this authorization will terminate or expire upon (state the specific date, event, or condition):	I,(Patient's Signature)	, authorize the release o	f HIV test	results and/o	or HIV treatment information.
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