

OCHSNER CLINIC FOUNDATION
HEALTH INFORMATION MANAGEMENT
RELEASE OF INFORMATION

According to the new HIPAA (Health Insurance Portability and Accountability Act) Regulations, enclosed you will find a form that must be filled out by the patient.

All aspects of the form must be filled out **COMPLETELY**.

To be valid, the Authorization must be properly filled out, dated and signed by the patient. The Authorization will terminate on the date indicated on the Authorization or when revoked in writing by the patient. If the patient is deceased and did not expire at this facility, and you are the next of kin, please include a copy of the death certificate.

Due to the volume of requests for copies of medical records received daily, Ochsner Health System contracts MRO (Medical Records Online) to copy and release the 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.

Service Charge:

Paper

\$0.20 per page

Electronic Delivery (CD/EMAIL)

\$0.20 up to \$100 (Max amount charged)

Plus, tax and postage

Please mail your authorization form to us at:

Ochsner Medical Center Westbank

Attn: Release of Information

2500 Belle Chasse Hwy

Gretna, LA 70056

If you have any questions regarding the release of your medical information, please contact the Release of Information Department (504) 391-5144.

I have read and agree with the explanation of charges.

Signature of patient or authorized representative

Date

(Revised 10/16/2013)

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-West Bank Campus 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 - West Bank Campus has already taken action in reliance on it. Letters to revoke this authorization should be addressed to Ochsner Medical Center - West Bank Campus, Release of Information Department, 2500 Belle Chasse Highway, Gretna, LA, 70056.

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

**Ochsner Medical Center - West Bank Campus
2500 Belle Chasse Highway
Gretna, LA 70056**

Phone: (504) 207-2525 Fax: (504) 391-5115

**AUTHORIZATION FOR RELEASE OF
CONFIDENTIAL INFORMATION**