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	Electronic Delivery (CD/EMAIL)
$0.20 per page	$0.20 up to $100 (Max amount charged)

Plus, tax and postage

Please mail your authorization form to us at:

Ochsner Medical Center and Health Center Baton Rouge
Attn: Release of Information
17000 Medical Center Dr.
Baton Rouge, LA 70816

If you have any questions regarding the release of your medical information, please contact the Release of Information Department (225) 236-5917 or (225) 755-4803.
If you are a patient and would like to submit your authorization via fax, you may fax to the Release of Information (225) 236-5469 or (225) 761-5939

I have read and agree with the explanation of charges.

_____ _____

Signature of patient or authorized representative Date

(Revised 07/17/14)

Ochsner Medical Center - Baton Rouge
17000 Medical Center Drive
Baton Rouge, LA 70816

Phone: (225) 236-5917 or (225) 755-4803
Fax: (225) 236-5469 or (225) 761-5939

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-Baton Rouge, Release of Information Department, 17000 Medical Center Drive, Baton Rouge, LA 70816

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