

Requests are processed within 15 business days of receipt.

Fees/charges comply with all federal and state laws and regulations applicable to release of PHI.

*Records stored electronically and delivered electronically - \$6.50

*Records stored in paper and delivered electronically - \$.90 flat rate plus \$0.07 p/page

*Records stored electronically/paper and delivered in paper - \$.90 flat rate plus \$0.12 p/page

*Taxes and postage will be applied.

*******Do not enclose payment. You will be invoiced fees*******

MAILING ADDRESS: 3700 ST CHARLES AVENUE*NEW ORLEANS, LA 70115* PHONE: 504-412-1476*FAX: 504-777-2921

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)
FROM LSU HEALTHCARE NETWORK**

Patient Name:	Date of Birth:	LSUHN Chart#:
Address:	Social Security Number:	
City:	State/Zip Code:	
Delivery Method:	Entity/Provider/Person Receiving PHI	
<input type="checkbox"/> Email secure format <input type="checkbox"/> USPS Mail <input type="checkbox"/> Fax (Healthcare Provider only)	Name: _____ Phone: _____ Fax: _____ Attention: _____	

Purpose of Disclosure

- Continuing/Establishing Care Treatment
 Personal
 Legal
 Social Security-Disability
 Daycare/School
 Insurance
 Other-specify: _____

PHI and Dates of PHI Authorized for Use and Disclosure

Description	Start Date	End Date
Complete Health record		
Progress notes		
Laboratory tests		
History & Physical Examination		
Consultation reports		
Radiology films		
Itemized billing statement		
Other:		

*State and Federal laws protect the following information.
If this information applies to you, please indicate if you would like the information released/obtained (indicate dates to be released where appropriate:*

Record Type	Dates:	Yes	No	
Alcohol, Drug, or Substance Abuse records	Dates:			
HIV Testing and Results	Dates:			
Mental Health	Dates:			
Psychiatry and Psychotherapy records	Dates:			

Signature of patient/personal/legal representative who may request disclosure:

1. Request for copies of medical records are subject to reproduction fees in accordance federal/state regulations.
2. Any disclosure of information carries the potential for unauthorized **RE-DISCLOSURE**. Re-disclosed information may not be protected by federal confidentiality rules
3. I the undersigned have read the above and authorize LSU Healthcare Network to disclose such information as herein contained.
4. I have the right to revoke this authorization at any time. Revocation must be written and presented in person or mailed to:
 - LSUHN Health Information Management Department, ROI, 2025 Gravier St, Suite 601, New Orleans, LA 70112
 - Revocation does not apply to **Information Previously Disclosed/ Released**.
 - Unless otherwise revoked, authorization will expire on the following date/event/condition _____. If I fail to specify an expiration date/event/condition, this authorization will expire **one (one) year from date signed**.
5. Treatment, payment, enrollment or eligibility is not a condition on whether I sign this authorization.

DATE	SIGNATURE- PATIENT/PARENT/CONSERVATOR/GUARDIAN	AUTHORITY-RELATIONSHIP TO PATIENT
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