LSU Health Healthcare Network

REQUESTS ARE PROCESSED WITHIN 15 (FIFTEEN DAYS OF RECEIPT)
FEES/CHARGES COMPLY WITH
*****FEES WILL BE INVOICED/BILLED. DO NOT ENCLOSE PAYMENT *****
TAXES AND POSTAGE FEES APPLY.
RECORDS STORED ELECTRONICALLY AND DELIVERED ELECTRONICALLY – $6.50
RECORDS STORED IN PAPER AND DELIVERED ELECTRONICALLY - $0.90 FLAT RATE PLUS $.07 PER PAGE
RECORDS STORED ELECTRONICALLY/PAPER AND DELIVERED IN PAPER - $.90 FLAT RATE PLUS $.012 PER PAGE

Mailing Address: 3700 St. Charles Avenue, New Orleans, La 70115 *Phone: 504-412-1476 * Fax: 504-777-2921 *
*******DO NOT FAX RECORDS TO 504-777-2921, FAX TO NUMBER INDICATED IN THE RECEIVING PHI BLOCK******

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name:	Date of Birth:	LSUHN Chart#:
Address:	Social Security Number:	
City:	State/Zip Code:	

Delivery Method:	Entity/Provider/Person Receiving PHI
☐Email secure format ☐USPS Mail ☐Fax (Healthcare Provider only)	Name:_____ Address_____ City:_____ State/Zip Code:_____ Phone: _____ Fax:_____ Attention:

Unless otherwise revoked, this authorization will expire on the following date/event/condition: ☐
If I fail to specify an expiration date/event/condition, this authorization will expire 1 (one) year from the date signed.

Purpose of Disclosure

☐ Continuing care/Treatment ☐ Personal ☐Legal ☐ Social Security Benefits-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:

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

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

1. *Request for copies of medical records are subject to reproduction fees in accordance with 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:*
   - *Health Information Management Department, ROI at 2025 Gravier Street, Suite 601, New Orleans, LA 70112.*
   - *Revocation does not apply to INFORMATION PREVIOUSLY DISCLOSED/RELEASED in response to this authorization.*
5. *Treatment, payment, enrollment or eligibility for benefits is not a condition on whether I sign this authorization.*

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