

One mailing address for all facilities or as indicated below:

LSU Healthcare Network Release of Information
1542 Tulane Ave., Suite 123HCN, New Orleans, LA 70112
Phone: 504-412-1476 Fax: 866-742-1905

(DO NOT FAX RECORDS TO THIS NUMBER, FAX TO REQUESTED NUMBER)

Note: Requests are processed within 15 business days of receiving requests. Fees/charges will comply with all laws and regulations applicable to release of PHI.

\$1.00 per page for pages 1-25

\$.50 per page for pages 26-500

\$.25 per page for pages 501 +

Actual postage for shipping

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

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

From LSU Healthcare Network facility From non-LSU Healthcare Network facility

Patient Name (Last, First, Middle):	Date of Birth:	SSN:	LSUHN Chart #
Address:		Telephone #	
Delivery Method: <input type="checkbox"/> Email secure format <input type="checkbox"/> USPS Mail <input type="checkbox"/> Fax (healthcare provider only)		Email address:	
RELEASE To: Please provide Name/Address of person/organization "TO" or "FROM" which disclosure is to be made			
Name:		Address:	
Fax :		Phone:	
DATES OF SERVICE to be released: _____ (Specify dates - this line <u>MUST BE</u> completed)			
<input type="checkbox"/> Continuing Care/Treatment <input type="checkbox"/> Personal <input type="checkbox"/> Legal <input type="checkbox"/> Applying for Social Security Disability <input type="checkbox"/> Daycare/School <input type="checkbox"/> Insurance <input type="checkbox"/> Other: (please specify:) _____			
Select Portions of Protected Health Information to be released:			
<input type="checkbox"/> Complete Health Record <input type="checkbox"/> Office Notes <input type="checkbox"/> X-Ray Tests/Reports <input type="checkbox"/> Complete Billing Record <input type="checkbox"/> Laboratory Test/Results <input type="checkbox"/> Psychotherapy Notes <input type="checkbox"/> Other: _____			
State and federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained (including dates where appropriate):			
Alcohol, Drug, or Substance Abuse Records: <input type="checkbox"/> YES <input type="checkbox"/> NO Dates: _____			
HIV Testing and Results <input type="checkbox"/> YES <input type="checkbox"/> NO Dates: _____			
Mental Health <input type="checkbox"/> YES <input type="checkbox"/> NO Dates: _____			
Psychotherapy Records <input type="checkbox"/> YES <input type="checkbox"/> NO Dates: _____			
Signature of Patient or Personal Representative Who May Request Disclosure:			
1. Request for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.			
2. I, the undersigned, have read the above and authorize LSU Healthcare Network to disclose such information as herein contained.			
3. I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Management Department at 1542 Tulane Ave, Suite 123HCN, New Orleans, LA 70112. Revocation will not apply to information that has already been disclosed in response to this authorization.			
4. Unless otherwise revoked, this authorization will expire on the following date/event/condition: _____. If I fail to specify and expiration date/event/condition, this authorization will expire 1 year from the date signed.			
5. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.			
6. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.			
_____	_____	_____	_____
Date	Signature of Patient/Parent/Conservator/Guardian	Authority/Relationship to Patient	