LSU Health
Healthcare Network

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	
☐Email secure format ☐USPS Mail ☐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:

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 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