LSU Health Healthcare Network

AUTHORIZATION TO DISCLOSE OR RELEASE PROTECTED HEALTH INFORMATION (PHI)

Patient Information (Please PRINT)

First Name:	Last Name:	
Middle Initial:	Date of Birth: _____/_____/_____ (MM/DD/YYYY)	
Street Address:		
City:	State:	Zip Code:
Home Phone Number:	Cell Phone Number:	
Email address (optional):		

AUTHORIZATION
I hereby authorize:

LSU Healthcare Network (LSUHN)
Attn: Compliance / Release of Information
478 S. Johnson Street, 6th Floor New Orleans, LA 70112

Phone: 504-412-1476
Fax: 504-777-2921
Email: HNROI@LSUHSC.EDU

To (Check ONE):	☐ To receive information from:	☐ To release information to:	☐ Myself – see info above
DELIVERY METHOD:	☐ Email Secure Format	☐ USPS Mail	☐ Fax (Healthcare Providers Only)
Street Address:			
City:	State:		Zip Code:
Telephone Number:	Fax Number:		

***Health Information to be used and/or disclosed under this authorization*:**

Dates of Service:	Start Date:	End Date:

❑ Abstract	❑ Complete Health Record	❑ Progress / Clinic Notes
❑ AVS – After Visit Summary	❑ Discharge Summary	❑ Radiology Reports
❑ Cardiology Reports	❑ Itemized Bill	❑ Radiology Films / Images
❑ Pathology / Lab Reports	❑ Immunization Records	
❑ Other:		

The below information (if any) will be released unless you specifically withhold authorization by initialing below:

AIDS or HIV test results:		Behavioral Health:	
Research:		Psychotherapy:	
Alcohol/substance abuse treatment:		Genetic Testing:	

Purpose of the use and/or disclosure (Check ONE): *("At my request" is a sufficient purpose for a patient initiating this request)*

❑ Continued Care ❑ Legal ❑ Insurance ❑ At my request ❑ Other:

Acknowledgement of Understanding:

- I understand that I may withdraw my authorization at any time except to the extent that action has been taken in reliance on this statement. Withdrawal must be in writing to the Compliance Department at the address listed above.
- I understand that this authorization statement will expire ***one year from the date*** signed unless I identify a different date, whichever is sooner.
- I understand that if I do or do not sign this form, my health care and the payment of my health care will not be affected.
- I understand that signing this form is voluntary. The LSU Healthcare Network may not condition treatment, payment, enrollment in health plans, or eligibility for benefits on my signing or refusal to sign this authorization, except in limited circumstances.
- I understand that once LSUHN discloses my PHI to the recipient, LSUHN cannot guarantee that the recipient will not re-disclose my PHI to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my PHI.
- I understand that I may inspect or copy the information to be used or disclosed, as provided by 42 CFR 164.524.
- I understand there is a charge for photocopies and records provided on electronic media, as permitted by Louisiana law, unless copies are sent directly to another healthcare provider.
- I understand the record may not be complete if there has been a recent visit, as additional documentation could be added after release.

Signature of patient or Legal Representative:	Date:
Printed Name of Patient or Legal Representative:	Relationship to Patient:
Representative's Authority to Act for Patient: ***(Attach supporting documentation)***	

LSU Health Healthcare Network

IMPORTANT INFORMATION ABOUT COMPLETING THE AUTHORIZATION TO DISCLOSE OR RELEASE PROTECTED HEALTH INFORMATION

NOTICE TO PATIENTS:

Please read this notice carefully and follow instructions for completing the authorization to release medical records.

Compliance Department Contact Information:

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478 S. Johnson Street, 6th Floor New Orleans, LA 70112

Phone: 504-412-1476
Fax: 504-777-2921
Email: HNROI@LSUHSC.EDU

Instructions for Completing Authorization:

1. Complete all sections on the "AUTHORIZATION TO DISCLOSE OR RELEASE PROTECTED HEALTH INFORMATION" form. Incomplete forms will not be accepted (mandated by the Federal Guidelines for HIPAA).
2. Form must be completed by patient or authorized patient representative, with appropriate identification.
3. If patient is deceased, did not expire at this facility, and you are the next of kin, please include a copy of the death certificate.
4. Please send (mail, fax, or email) your completed Authorization to Release Protected Health Information form TO the appropriate location listed above.
5. If you have any questions regarding the release of your medical information, please contact the LSU Healthcare Network Compliance Department at the location listed above.

Important Information about Authorization:

This authorization will expire in one (1) year or on the date you indicated on the Authorization, whichever is sooner, or when revoked in writing by the patient or legal representative.

Note: The LSU Healthcare Network contracts with a 3rd party vendor (CIOX) to assist with Medical Record Requests. You may be assessed a reasonable reproduction and handling fee (as stipulated in Louisiana Revised Statute §40:1165.1).