5620 READ BLVD, NEW ORLEANS, LA 70127
Phone: (504)592-6590 Fax:(504)592-6599

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________________ Date of Birth: ______________________

Address: ______________________________ Phone Number: ______________________

I request and **authorize** ______________________________ to release healthcare information of the patient named above **to**:

Name: ____

Address: ____

City: ______________________State: __________ Zip Code: ____________

This request and authorization applies to the **dates of services:** ________________to ________________

Items to be released include:

☐History and Physical ☐Pathology ☐Consults ☐Lab Results
☐Discharge Summary ☐Cardiology ☐Radiology Report ☐Radiology Images/Film
☐Operative Report ☐Outpatient Records ☐Entire Record ☐Abstract
☐Psychiatric and other mental health records ☐Records related to Alcohol or Drug Abuse
☐Other ______________________________

Purpose of Release: ☐ Legal ☐ Insurance ☐ Medical ☐ Other ______________________________

Method of Delivery: ☐ Patient to Pick up ☐ Please mail
☐ Please fax to______________________ ☐ Please email to ______________________

☐Yes ☐No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results.
☐Yes ☐No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.
☐Yes ☐No I authorize the release of psychiatric information.
☐Yes ☐No I authorize the release of genetic testing.

I may revoke this authorization at any time by written notice to the covered entity. This authorization shall expire **ninety days** after it is signed, unless validly revoked prior to that date. The covered entity may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign an authorization. Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by HIPAA regulations. This authority shall supersede any prior agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information. I have a right to a copy of this authorization.
I understand that there may be a fee related to obtaining records from the contracted services, however, medical information will be forwarded to hospitals and physicians free of charge.

______________________________ ______________________
PATIENT SIGNATURE/REPRESENTATIVE SIGNATURE RELATIONSHIP TO PATIENT

______________________________ ______________________
PRINTED NAME IF SIGNED ON BEHALF OF PATIENT DATE SIGNED