New Orleans East Hospital
LCMC Health

AFFIX PATIENT LABEL

RI0010

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** N.O.E.H _____ 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