



## AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

(See back of form for facility locations)

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

I, \_\_\_\_\_, hereby authorize

FULL NAME OF PATIENT

to release information specified below from my

NAME OF HOSPITAL / PHYSICIAN / FACILITY \_\_\_\_\_ medical records covering the dates of service \_\_\_\_\_ to \_\_\_\_\_

The information which is checked (X) below is to be released to:

NAME OF PERSON, HOSPITAL, PHYSICIAN, SERVICE AGENCY OR THIRD PARTY (Provide fax # if hospital or physician)

ADDRESS CITY STATE ZIP

Purpose for Release:  Medical  Insurance  Legal  Other

\*Purpose of Release is not required for patient/personal representative requests.

Check off items being released:

<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Laboratory	<input type="checkbox"/> X-ray Report
<input type="checkbox"/> Discharge Instructions/After Visit Summary	<input type="checkbox"/> Cardiology	<input type="checkbox"/> Radiology films
<input type="checkbox"/> History & Physical	<input type="checkbox"/> Clinic Visit	<input type="checkbox"/> ER Record
<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> Abstract	<input type="checkbox"/> Entire Record
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Operative Report	<input type="checkbox"/> Billing Record
<input type="checkbox"/> Pathology Reports		Other _____

Method of Delivery:  Paper  Fax # \_\_\_\_\_  CD  Email \_\_\_\_\_

The patient's express authorization is required to release certain types of records, including alcohol and/or drug abuse treatment and information, HIV testing and treatment, psychiatric treatment, and genetic testing (defined in the Genetic Information Non-Discrimination Act of 2008 - GINA, section 201 7 A and B). To authorize release of this information, please read and sign the following:

I, \_\_\_\_\_, authorize the release of **alcohol and/or drug abuse** treatment and information.

(Patient's Signature)

I, \_\_\_\_\_, authorize the release of **HIV test results** and/or HIV treatment information.

(Patient's Signature)

I, \_\_\_\_\_, authorize the release of **psychiatric** information.

(Patient's Signature)

I, \_\_\_\_\_, authorize the release of **genetic testing** information.

(Patient's Signature)

In authorizing the release of the confidential information identified above, I hereby waive all restrictions or privileges imposed by law and release Ochsner Health System and its affiliates and their staff from any restriction or privilege imposed by law in connection with the disclosure or release of any professional record, observation or communication. I do understand that the information that is being released may be subject to re-disclosure by the recipient and may no longer be protected. I understand that my treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.

This authorization may be revoked in writing at any time, except to the extent that Ochsner Health System and its affiliates have already taken action in reliance on it. Letters to revoke this authorization should be addressed to Ochsner Medical Center, Release of Information Department, 1201 Dickory Avenue, Harahan, LA 70123.

If not previously revoked in writing, this authorization will terminate or expire upon (state the specific date, event, or condition):

If expiration date is left blank, authorization will expire within one year.

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE

RELATIONSHIP TO PATIENT

DATE SIGNED

ADDRESS

PHONE NUMBER

SIGNATURE OF WITNESS (if patient is unable to sign)

RELATIONSHIP TO PATIENT OR CREDENTIALS

DATE SIGNED

FOR HIM USE ONLY: Date Rec'd \_\_\_\_\_ Date Processed \_\_\_\_\_ Time Frame \_\_\_\_\_ Processed By \_\_\_\_\_ # Pages/Amount \_\_\_\_\_

## FACILITY LOCATIONS

ATTN: Release of Information  
**Ochsner Medical Center**  
**Ochsner Health Centers**  
1514 Jefferson Highway  
New Orleans, LA, 70121  
Phone: (504) 842-2832  
Fax: (504) 842-4047

ATTN: Release of Information  
**Ochsner Medical Complex**  
**Christus Ochsner Health Centers**  
1514 Jefferson Highway  
New Orleans, LA, 70121  
Phone: (504) 842-2832  
Fax: 504-842-4047

*Request for medical records for visits ON or AFTER after Feb. 17, 2019 contact: should be addressed to the following for processing: Ochsner Medical Center- Ochsner Health Centers*

ATTN: Release of Information  
**Ochsner Medical Center**  
**Kenner Ochsner Health Centers**  
180 West Esplanade Avenue  
Kenner, LA, 70065  
Phone: (504) 464-8066  
Fax: (504) 464-8093

ATTN: Release of Information  
**Ochsner Medical Center**  
**Ochsner St. Mary**  
1125 Marguerite St.  
Morgan City, LA 70380  
Phone: 985-380-4530  
Fax: 985-380-4533

ATTN: Release of Information  
**Slidell Memorial Hospital East**  
100 Medical Center Dr  
Slidell, LA, 70461  
Phone: (985)-646-5009  
Fax: (985)-646-5606

ATTN: Release of Information  
**Ochsner Baptist Medical Center**  
**Ochsner Health Centers**  
2700 Napoleon Avenue  
New Orleans, LA, 70115  
Phone: (504) 894-2173  
Fax: (504) 894-2460

ATTN: Release of Information  
**Ochsner Medical Center North Shore**  
**Ochsner Health Centers**  
100 Medical Center Drive  
Slidell, LA, 70461  
Phone: (985) 646-5009  
Fax: (985) 646-5606

ATTN: Release of Information  
**Ochsner Medical Complex**  
**River Parishes**  
500 Rue de Sante  
Laplace, LA, 70068  
*Request for medical records for visits ON or AFTER Nov. 1, 2014 contact: Ochsner Medical Center - Kenner*

ATTN: Release of Information  
**Ochsner Medical Center**  
**Westbank Ochsner Health Centers**  
2500 Belle Chasse Highway  
Gretna, LA 70056  
Phone: (504) 207-2525  
Fax: (504) 391-5115

ATTN: Release of Information  
**Slidell Memorial Hospital**  
1001 Gause Blvd  
Slidell, LA, 70458  
Phone: (985)-280-1706  
Fax: (985)-280-8897

ATTN: Release of Information  
**Ochsner Medical Center Baton Rouge**  
**Ochsner Health Centers**  
17000 Medical Center Drive  
Baton Rouge, LA, 70816  
Phone: (225) 236-5917  
Fax: (225) 236-5469  
or (225) 761-5939

ATTN: Release of Information  
**Ochsner Medical Center**  
**Hancock Ochsner Health Centers**  
149 Drinkwater Blvd.  
Bay St. Louis, MS, 39520  
Phone: (228) 467-8714  
Fax: (228) 467-8704

ATTN: Release of Information  
**Ochsner St. Anne General**  
**Ochsner Health Centers**  
4608 Hwy One  
Raceland, LA, 70394  
Phone: (985) 537-8364  
Fax: (985) 537-8296

ATTN: Release of Information  
**Ochsner American Legion - Jennings**  
1324 Elton Drive  
Jennings, LA, 70546  
Phone: (337)-616-7076  
Fax: (337)-616-7078



## Health Information Management Release of Information

**Due to the volume of request for copies of medical records received daily, Ochsner Health System contracts MRO (Medical Records Online) to copy and release medical records. For this service, there is a fee mandated by law, however medical information will be forwarded to hospitals and physicians free of charge.**

**For copies of your records, you may be assessed a fee based on the following fee schedule:**

Pages of Records	Format you will receive the records	Reasonable, Cost-Based Fee
<b>1-50 pages</b>	Paper (Picked Up)	No charge
<b>51-and up</b>	Paper (Picked Up)	\$6.50 plus tax
<b>Any number of pages</b>	Electronic (Email or CD)	\$6.50 plus tax and postage
<b>Any number of pages</b>	Paper (Mailed)	\$6.50 plus tax and postage

**Once the records are ready, you will be notified via mail. Please review the invoice for payment information. Payment may be made by check, credit card or money order.**

**Please note, records from another facility contained within the requested records may be released.**

**Please call 610.994.7500 Ext. 1 to check the status of your request, make a payment or ask any questions about your request.**