Ochsner Health System | LSU Health SHREVEPORT

ST. MARY MEDICAL CENTER

1 Saint Mary Place • Shreveport, LA 71101 • Phone: 318-626-2069 • Fax: 318-698-4294

Authorization for Use and Disclosure of Protected Health Information

Patient Identification:

Printed Name: ______________________________ Date of Birth: ______________________________

Complete Address: ____

Social Security #:______________________________ Telephone:(______) ______________________________

Information to be Released – Covering the Periods of Health Care

From (date) ______________________________ to (date) ______________________________

Please check type of information to be released:

- ☐ Complete health record
- ☐ History and physical exam
- ☐ Laboratory test results
- ☐ Photographs, videotapes
- ☐ Discharge instructions
- ☐ Diagnosis and treatment codes
- ☐ Consultation reports
- ☐ Radiology reports/images
- ☐ Complete billing record
- ☐ Pulmonary function results
- ☐ Discharge summary
- ☐ Progress notes
- ☐ Cardiac imaging
- ☐ Itemized bill
- ☐ Other (specify):____

Purpose of Request

☐ Treatment or consultation ☐ At the request of the patient ☐ Billing or claims payment

(Indicate which applies) ☐ Send To / ☐ Obtain Information From:

☐ Paper ☐ CD ☐ Electronic Portal ☐ Email

Release to Name: ______________________________ Email: ______________________________

Name: ______________________________ Phone #:______________________________

Address: ______________________________ Fax #: ______________________________

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

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, ______________________________ (Patient's Signature) authorize the release of **alcohol and/or drug abuse** treatment and information.

I, ______________________________ (Patient's Signature) authorize the release of **HIV test results** and/or HIV treatment information.

I, ______________________________ (Patient's Signature) authorize the release of **psychiatric information.**

I, ______________________________ (Patient's Signature) authorize the release of **genetic testing** information.

Time Limit and Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to Ochsner LSU Health Shreveport, St. Mary Medical Center, 1 Saint Mary Place, Shreveport, LA 71101. Unless revoked, this authorization will expire on the following date or event____________________or 180 days from the date of signature.

In authorizing the release of the confidential information identified above, I hereby waive all restrictions or privileges imposed by law and release Ochsner LSU Health, St. Mary Medical Center, Shreveport 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.

I authorize Ochsner LSU Health Shreveport, St. Mary Medical Center to release the protected health information specified above.

Signature: ______________________________ Date: ______________________________

Authority of Personal Representative to Request Disclosure:______________________________

Identify of Requestor Verified via: ☐ Photo ID ☐ Other, specify: ______________________________