Ochsner Medical Center - Baton Rouge
17000 Medical Center Drive
Baton Rouge, LA 70816

Phone: (225) 755-4801 Fax: (225) 755-4918

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient's Name ______________________ Date of Birth ______________

Address ____

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 HOSPITAL, PHYSICIAN, SERVICE AGENCY OR THIRD PARTY

____
ADDRESS CITY STATE ZIP

Purpose for Release: ☐ Medical ☐ Insurance ☐ Legal ☐ Other ______________

Check off items being released:

- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Consultation Reports
- ☐ Pathology Reports
- ☐ Laboratory
- ☐ Cardiology
- ☐ Clinic Visit
- ☐ Hospital admission
- ☐ Abstract ( )
- ☐ Dictated Letter
- ☐ Other ______________
- ☐ Operative Report
- ☐ X-ray Report
- ☐ ER Record
- ☐ Entire Record

Method of Delivery: ☐ paper ☐ Electronic delivery: Email address: ______________

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, and psychiatric treatment. 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)

In authorizing the release of the confidential information identified above, I hereby waive all restrictions or privileges imposed by law and release Ochsner Medical Center and Ochsner Health Centers and its 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 Medical Center and Ochsner Health Centers have already taken action in reliance on it. Letters to revoke this authorization should be addressed to Ochsner Medical Center-Baton Rouge, Release of Information Department, 17000 Medical Center Drive, Baton Rouge,

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

______________________ ADDRESS

______________________ DATE SIGNED

______________________ PHONE NUMBER