Ochsner

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:

- ☐ Discharge Summary
- ☐ Discharge Instructions/After Visit Summary
- ☐ History & Physical
- ☐ Consultation Reports
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ Laboratory
- ☐ Cardiology
- ☐ Clinic Visit
- ☐ Abstract
- ☐ Operative Report
- ☐ X-ray Report
- ☐ Radiology films
- ☐ ER Record
- ☐ Entire Record
- ☐ Billing Record

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
Rush Foundation Hospital
1314-19th Avenue
Meridian, MS 39301
Phone: 601-703-9675
Fax: 601-703-6742

ATTN: Release of Information
Laird Hospital
25117 Highway 15
Union, MS 39365
Phone: 601-774-1554
Fax: 601-774-5401

ATTN: Release of Information
Choctaw General Hospital
501 Vanity Fair Avenue
Butler, AL 36904
Phone: 205-459-9174
Fax: 205-459-9190

ATTN: Release of Information
Specialty Hospital Of Meridian (LTACH)
1314- 19th Avenue
Meridian, MS 39301
Phone: 601-703-4541
Fax: 601-703-3266

ATTN: Release of Information
H.C. Watkins Memorial Hospital
605 South Archusa Avenue
Quitman, MS 39355
Phone: 601-776-6925
Medical Records ext: 2128
Fax: 601-776-7158

ATTN: Release of Information
Scott Regional Hospital
317 Highway 13 South
Morton, MS 39117
Phone: 601-732-1003
Fax: 601-732-2700

ATTN: Release of Information
John C. Stennis Memorial Hospital
14365 Highway 16 West
DeKalb, MS 39328
Phone: 769-486-1034
Fax: 769-486-1099

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
1-50 pages	Paper (Picked Up)	No charge
51-and up	Paper (Picked Up)	$6.50 plus tax
Any number of pages	Electronic (Email or CD)	$6.50 plus tax and postage
Any number of pages	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.