

East Bank – Jefferson Highway – Release of Information

Hours of Operation: 8:00 a.m. to 5:00 p.m. Monday – Friday

Telephone: (504) 842-2832

Fax (504) 842-4047

Location: HIM Clinic Department – 1st Floor

Overview of Functions

As a patient, your medical information is kept in the strictest confidence, and safeguarding your patient information is of the utmost importance. As such, the release of information (ROI) staff is responsible for ensuring the appropriate authorization and timely release of medical records. The ROI staff process and disseminate patient information requested by patients, physicians, and other outside requestors.

How to Obtain Copies of Your Records

You have the right to review and request copies of medical information that may be used to make decisions about your care. To review or obtain copies of medical information, you must submit your request in writing to:

*Ochsner Medical Center
Health Information Management Department
Attention: Release of Information
1514 Jefferson Hwy.
New Orleans, LA 70121*

You may request the copies in person or mail the request form to the above address. For your convenience, you may print and complete the authorization form below.

Ochsner may charge a fee for the costs of copying, mailing, and other supplies associated with your request. Fees for obtaining copies of records are noted below.

Fee Schedule

\$1.00 per page for pages 1 through 25

\$.50 per page for pages 26 through 350

\$.25 per page for 351+ pages

Plus, tax and postage

Copies of records are submitted to other physicians or medical providers at no cost.

Ochsner Medical Center
Ochsner Health Centers
1514 Jefferson Highway
New Orleans, LA 70121

Phone: (504) 842-2832 Fax: (504) 842-4047

**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:

- | | | |
|---|---|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Cardiology | <input type="checkbox"/> Operative Report |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Clinic Visit | <input type="checkbox"/> X-ray Report |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Hospital admission | <input type="checkbox"/> ER Record |
| <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Abstract () | <input type="checkbox"/> Entire Record |
| <input type="checkbox"/> Laboratory | <input type="checkbox"/> Dictated Letter | |
| | <input type="checkbox"/> Other _____ | |

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, Release of Information Department, 1514 Jefferson Highway, New Orleans, LA, 70121.

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



**OCHSNER CLINIC FOUNDATION
HEALTH INFORMATION MANAGEMENT
RELEASE OF INFORMATION**

According to new HIPAA (Health Information Portability and Accountability Act) Regulations, enclosed you will find a form that must be filled out by the patient.

All aspects of the form must be filled out **COMPLETELY**.

To be valid, the **Authorization** must be properly filled out, dated and signed by the patient. The Authorization will terminate on the date indicated on the **Authorization** or when revoked in writing by the patient. If the patient is deceased and did not expire at this facility, and you are the next of kin, please include a copy of the Death Certificate.

Due to the volume of requests for copies of medical records received daily, Ochsner Clinic Medical Center contracts HealthPort, to copy and release the medical records. For this service of providing copies of medical records, there is a fee allowed by law to cover associated costs. However, medical information will be forwarded to hospitals and physicians free of charge.

Fee Schedule:

Service Charge:

\$1.00 per page (1-25 pages)
\$0.50 per page (26-350 pages)
\$0.25 per page (351 + pages)
Plus, tax and postage

Please mail your Authorization form to us at:

Ochsner Medical Center
Attn: Release of Information
1514 Jefferson Highway
New Orleans LA 70121

If you have any questions regarding the release of your medical information, please contact the Release of Information Department (504) 842-2832.

I have read and agree with the above explanation of charges.

Signature of patient or authorized representative

Date:

(Revised 08/13/2010)