

**Ochsner Medical Center, Ochsner Hospital - Elmwood, and all Ochsner Clinic Locations
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 and 504-842-5037

Location: Health Information Management Department – 1st Floor of Clinic

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.

*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, by mailing the request form to the above address or by faxing to the fax number listed above. For your convenience, you may print and complete the authorization form from this website.

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 – 500

\$.25 per page for > 501 pages

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

Form No. 20048 (Rev. 8/24/2010)

CORRESPONDENCE

