LCMC Health

AUTHORIZATION TO DISCLOSE OR RELEASE PROTECTED HEALTH INFORMATION

PATIENT INFORMATION

PLACE PATIENT'S LABEL HERE

Patient Information (Please PRINT):

First Name: _____ Last Name: _____

Middle Name: _____ Date of Birth: ____/____/_____(MM/DD/YYYY)

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Cell Phone Number: _____

Email address: _____

I hereby authorize LCMC Health and/or any LCMC Health affiliates. (See separate Hospital / Clinic reference list if needed)

❑ **Hospital** *(please specify):* _____ Phone Number: (844) 324-6205 option 1

Fax Number: (504) 962-7016

❑ **Clinic/Provider** *(please specify):*_____ Email: ROI@LCMCHealth.org

Preferred delivery method *(for patient personal requests only)*: ❒ Email (secure) ❒ Mail ❒ MyChart Portal ❒ Onsite

(Check ONE): ❑ Receive information from: ❑ Release information to: ❑ Release to self (*see info above*)

Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number:_____ Fax Number: _____

***Health Information to be used and/or disclosed under this authorization*:**

Dates of Service: Start Date: _____ End Date: _____

❑ Abstract	❑ Complete Health Record	❑ Itemized Bill	❑ Progress / Clinic Notes
❑ After Visit Summary	❑ Discharge Summary	❑ Immunization Records	❑ Radiology Reports
❑ Autopsy Report	❑ Emergency Room Record	❑ Operative Report	❑ Radiology Films / Images
❑ Cardiology Reports	❑ History and Physical	❑ Pathology / Lab Reports	
❑ Other:			

*The below information will **NOT** be released unless you specifically authorized by initialing below:*

AIDS or HIV test results:		Behavioral Health Information:	
Alcohol/substance abuse treatment:		Genetic Testing:	

Purpose of the use and/or disclosure (Check ONE): *("At my request" is a sufficient purpose for a patient initiating this request)*

❑ Continued Care ❑ Legal ❑ Insurance ❑ At my request ❑ Other:

Acknowledgement of Understanding:

- I understand that I may withdraw my authorization in writing at any time except to the extent that action has been taken in reliance on this statement. Withdrawal must be made in writing and can be emailed to ROI@LCMCHealth.org or mailed to HIM Department - UMCNO 2000 Canal Street, New Orleans, LA 70112.
- I understand that this authorization statement will expire in ***one year from the date*** signed unless I identify a different date: _____; whichever is sooner.
- I understand that signing this form is voluntary. LCMC Health may not condition treatment, payment, enrollment in health plans, or eligibility for benefits on my signing or refusal to sign this authorization, except in limited circumstances.
- I understand that once LCMC Health discloses my PHI to the recipient, LCMC Health cannot guarantee that the recipient will not redisclose my PHI to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my PHI.
- I understand that I may inspect or copy the information to be used or disclosed, as provided by 42 CFR 164.524
- I understand there is a charge for photocopies and records provided on electronic media, as permitted by Louisiana law, unless copies are sent directly to another healthcare provider.
- I understand the record might not be complete, if it is a recent visit, and additional documentation could be added after submitting.

Signature of patient or Legal Representative:	Date:
Printed Name of Patient or Legal Representative:	Relationship to Patient:
Representative's Authority to Act for Patient: ***(Attach supporting documentation)***	

LCMC Health

IMPORTANT INFORMATION ABOUT COMPLETING THE AUTHORIZATION TO DISCLOSE OR RELEASE PROTECTED HEALTH INFORMATION

Notice to patients:
Please read this notice carefully and follow instructions for completing the authorization to release medical records.

Health Information Management (HIM) department contact information:

University Medical Center New Orleans ATTN: HIM Department 2000 Canal Street New Orleans, LA 70112	Phone Number:	(844) 324-6205 option 1
	Fax Number:	(504) 962-7016
	Email address:	ROI@LCMCHealth.org

Instructions for completing authorization:

1. Complete all sections on the “AUTHORIZATION TO DISCLOSE OF RELEASE PROTECTED HEALTH INFORMATION" form. Incomplete forms will not be accepted (mandated by the Federal Guidelines for HIPAA).
2. Form must be completed by patient or authorized patient representative, with appropriate identification.
3. If patient is deceased, did not expire at this facility, and you are the next of kin, please include a copy of the death certificate.
4. Please send (mail, fax, or email) your completed Authorization to Release Protected Health Information form to the appropriate location listed above.
5. If you have any questions regarding the release of your medical information, please contact the HEALTH INFORMATION MANAGEMENT DEPARTMENT at the location listed above.

Important information about authorization:

The authorization will terminate on the date indicated on the Authorization or when revoked in writing by the patient

Due to the volume of requests, LCMC Health contracts with a 3rd party vendor to assist with Medical Record Requests (MRO Corporation).

Patient rates:

All formats including paper, electronic delivery, and CD

- Flat rate $6.50 plus tax and postage (if applicable)

LCMC Health

LCMC HEALTH HOSPITAL AND CLINIC REFERENCE LIST

Children's Hospital New Orleans
200 Henry Clay Avenue
New Orleans, LA 70118

Children's Hospital Pediatrics
(Various Locations/Provider)

Children's Hospital Specialty Care
(Various Locations/Provider)

East Jefferson General Hospital (EJGH)
4200 Houma Boulevard
Metairie, LA 70006

EJGH Clinics
(Various Locations/Providers)

New Orleans East Hospital (NOEH)
5620 Read Boulevard
New Orleans, LA 70127

NOEH Clinics / NOLA Physician Group
(Various locations / Providers)

Lakeside Hospital
4700 S I-10 Service Road West
Metairie, LA 70001

Lakeview Hospital
95 Judge Tanner Boulevard
Covington, LA 70433

Lakeview Regional Physician Group (LRPG Clinics) *(Various locations / Providers)*

Touro Infirmary New Orleans – Hospital
1401 Foucher Street
New Orleans, LA 70115

Touro Clinics / Cresent City Physicians Inc. (CCPI)
(Various locations / Providers)

Tulane Medical Center (Hospital)
1415 Tulane Avenue
New Orleans, LA 70112

Tulane Clinics
(Various locations / Providers)

University Medical Center New Orleans (Hospital)
(UMCNO)
2000 Canal Street
New Orleans, LA 70112

UMCNO Clinics
(Various Locations/Providers)

West Jefferson Medical Center (WJMC) - Hospital
1101 Medical Center Boulevard
Marrero, LA 70072

WJMC Clinics / New Orleans Physicians Services (NOPS)
(Various Locations/Providers)