Touro 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 Initial:	Date of Birth: _____/ _____/ _____ (MM/DD/YYYY)	
Street Address:		
City:	State:	Zip Code:
Home Phone Number: ( )	Cell Phone Number: ( )	
Email address (optional):		

I hereby authorize (Check ONE):

❑ **Touro Infirmary**
Attention:
Release of Information
1401 Foucher St.
New Orleans, LA 70115

Phone Number: (504) 897-8411
Fax Number: (504) 897-7275
Email:
TIMedicalRecords@lcmchealth.org

❑ **CCPI - Crescent City Physicians**
Physician / Clinic Name:_____

3600 Prytania Street,
Suite 35
New Orleans, LA 70115

Phone Number: (504) 897-8411
Fax Number: (504) 249-5511
Email:TIMedicalRecords@lcmchealth.org

To (Check ONE): ❑ To receive information from: ❑ To release information to: ❑ Myself – see info above ❑Through Patient Portal

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
❑ AVS – After Visit Summary
❑ Autopsy Report
❑ Cardiology Reports
❑ Complete Health Record
❑ Discharge Summary
❑ Emergency Room Record
❑ History and Physical
❑ Itemized Bill
❑ Immunization Records
❑ Operative Report
❑ Pathology / Lab Reports
❑ Progress / Clinic Notes
❑ Radiology Reports
❑ Radiology Films / Images
❑ 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 taking in reliance on this statement. Withdrawal must be made in writing and presented or mailed to the Health Information Management Department at the address listed above.
- 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 if I do not sign this form, my health care and the payment of my health care will not be affected.
- 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)***

Touro
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:

Touro Infirmary Attention: Release of Information 1401 Foucher St. New Orleans, LA 70115	Phone Number:	(504) 897-8411	**CCPI - Crescent City Physicians** 3600 Prytania Street, Suite 35 New Orleans, LA 70115	Phone Number:	(504) 897-8411
	Fax Number:	(504) 897-7275		Fax Number:	(504) 249-5511
	Email: TIMedicalRecords@lcmchealth.org			Email: TIMedicalRecords@lcmchealth.org	

Instructions for Completing Authorization:

1. Complete all sections on the "AUTHORIZATION TO DISCLOSE OR 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

- Service Charge:
  Paper 10¢ per page plus tax and postage
  Electronic 10¢ per page
- Electronic Delivery or CD:
  Flat fee of $6.50

This form is NOT part of the Legal Medical Record