St. **Bernard** Parish Hospital
Health Information Management
8000 West Judge Perez Drive
Chalmette, LA 70043
Phone: **(504) 826-9580** Fax: (**504) 826-9584**

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

MR# _____

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 HOSPITAL, PHYSICIAN, SERVICE AGENCY OR THIRD PARTY

_____
ADDRESS CITY STATE ZIP

_____
TELEPHONE NUMBER FAX NUMBER

Purpose for Release: ☐ Medical ☐ Insurance ☐ Legal ☐ Other _____
*Purpose for Release is not required for patient/personal representative requests.

Check off items being released:

☐ Discharge Summary	☐ Consultation Reports	☐ Clinic Visit	☐ Operative Report
☐ Discharge Instructions/After Visit Summary	☐ Pathology Reports	☐ Hospital admission	☐ X-ray Report
☐ History & Physical	☐ Mammogram	☐ Abstract ( )	☐ ER Record
☐ Diagnosis/Face Sheet	☐ Laboratory	☐ Dictated Letter	☐ Entire Record
☐ Physician Progress Notes	☐ Cardiology	☐ 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, 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 St. Bernard Parish Hospital 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 St. Bernard Parish Hospital has already taken action in reliance on it. Letters to revoke this authorization should be addressed to St. Bernard Parish Hospital, Health Information Management Department, 500 West Judge Perez Drive, Chalmette, LA 70043.

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 RELATIONSHIP TO PATIENT OR CREDENTIALS DATE SIGNED

FOR HIM USE ONLY: Date Rec'd _____ Date Processed _____ Processed By _____ # Pages/Amount _____

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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:

How the PHI is Maintained	Requested Format of PHI	Reasonable, Cost-Based Fee
Electronically Hybrid (Electronic and Paper)	Electronic (Email or CD-ROM)	Flat fee of $6.50 (inclusive of actual labor, supplies and postage), plus applicable sales tax
Paper or Electronically Hybrid (Electronic and Paper)	Paper	$0.10 per page ($0.08 per page for actual labor and $0.02 per page for supplies), plus applicable postage and sales tax
Paper	Electronic (Email or CD-ROM)	$0.08 per page (actual labor), plus applicable postage and sales tax

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. Your requested records will then be mailed to you.

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.