LSU Health
Healthcare Network

One mailing address for all facilities or as indicated below:
LSU Healthcare Network Release of Information
2025 Gravier St., Suite 601, New Orleans, LA 70112
Phone: 504-412-1476 Fax: 504-412-1952 or 866-742-1905
(DO NOT FAX RECORDS TO THIS NUMBER, FAX TO REQUESTED NUMBER)

Note: Requests are processed within 15 business days of receiving requests.
Fees/charges will comply with all laws and regulations applicable to release of PHI.

- Records stored electronically and delivered electronically- $6.50
- Records stored in paper and delivered electronically- $0.90 flat rate plus $0.07 per page
- Records stored electronically/ paper and delivered in paper- $0.90 flat rate plus $0.12 per page
- Taxes and postage will be applied.

*****Do not enclose payment. You will be invoiced for fees*****

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

☐ **From LSU Healthcare Network facility** ☐ **From non-LSU Healthcare Network facility**

Patient Name (Last, First, Middle):	**Date of Birth:**	**SSN:**	**LSUHN Chart #**

Address:	**Telephone #**

Delivery Method: ☐ **Email secure format** ☐ **USPS Mail** ☐ **Fax (healthcare provider only)**	**Email address:**

RELEASE To: Please provide Name/Address of person/organization "TO" or "FROM" which disclosure is to be made

Name:	**Address:**
Fax :	**Phone:**

DATES OF SERVICE to be released: _____

(**Specify dates - this line MUST BE completed**)

☐ Continuing Care/Treatment ☐ Personal ☐ Legal ☐ Applying for Social Security Disability

☐ Daycare/School ☐ Insurance ☐ Other: (please specify:) _____

Select Portions of Protected Health Information to be released:

☐ Complete Health Record ☐ Office Notes ☐ X-Ray Tests/Reports

☐ Complete Billing Record ☐ Laboratory Test/Results

☐ Psychotherapy Notes ☐ Other: _____

State and federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained (including dates where appropriate:)

Alcohol, Drug, or Substance Abuse Records: ☐ **YES** ☐ **NO** **Dates:** _____
HIV Testing and Results ☐ **YES** ☐ **NO** **Dates:** _____
Mental Health ☐ **YES** ☐ **NO** **Dates:** _____
Psychotherapy Records ☐ **YES** ☐ **NO** **Dates:** _____

Signature of Patient or Personal Representative Who May Request Disclosure:

1. Request for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
2. I, the undersigned, have read the above and authorize LSU Healthcare Network to disclose such information as herein contained.
3. I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Management Department at 1542 Tulane Ave, Suite 123HCN, New Orleans, LA 70112. Revocation will not apply to information that has already been disclosed in response to this authorization.
4. Unless otherwise revoked, this authorization will expire on the following date/event/condition: _____. If I fail to specify and expiration date/event/condition, this authorization will expire **1 year from the date signed.**
5. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
6. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

_____ _____ _____
Date Signature of Patient/Parent/Conservator/Guardian Authority/Relationship to Patient