Tulane University Medical Group

Tulane DOCTORS

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Tulane University Medical Group must obtain a written authorization from a patient or their Personal Representative prior to releasing Protected Health Information, unless a legal exception applies. This form must be fully and completely filled out to be valid. A reasonable copying and handling charge may be charged for this request pursuant to La. R.S. 40:1165.1.

PATIENT AND RECIPIENT'S INFORMATION

I hereby authorize Tulane University Medical Group to release Protected Health Information on the patient listed below.

THE RECORDS OF: *(Patient's Information)*		**DELIVER TO:** *(Recipient's Information)*	
Name:	________	Name:	________
DOB (MM-DD-YYYY):	________	Address:	________
Address:	________	Phone:	________
Phone:	________	Fax:	________

PURPOSE OF DISCLOSURE

☐ Treatment ☐ Personal ☐ Legal ☐ Insurance

SPECIFIC TREATMENT PERIODS

Specific treatment date or time period for which the information is requested:

☐ Single treatment date of ______________________.
☐ Period of treatment from ______________________ to ________________________.
☐ Any and all treatment encounters to date.

DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED

Specific description of information to be used or disclosed. (*Check only those that apply or select All Records.*)

Medical Records

☐ Progress Notes
☐ Doctor's Orders
☐ Billing Records
☐ Nurse's Notes
☐ Lab Reports
☐ Immunization Records
☐ Other Medical Records:
(Please Describe)___________
____
____

Mental Health Records

☐ Mental Health Records
☐ Psychotherapy Notes

*This is the only item you may request on this authorization. You must submit another authorization for other items requested.

All Records

☐ Health Treatment and Billing Records

I hereby consent to release my HIV test results: _________ (Initial) I have a right to refuse to release my HIV test results, except where release is authorized by law without my consent.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected.
3. I may revoke this authorization at any time in writing.
4. If the receiver is not a health care provider, the information may no longer be protected by federal privacy regulations.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee.
6. I may have a copy of this form after I sign it.

SIGNATURES

I have read the above and authorize the disclosure of the Protected Health Information as stated.

Signature of Patient/Personal Representative:	Date:
Print Name of Patient's Personal Representative (*Authority document must be attached*):	Relationship to Patient

OFFICE USE ONLY

RECEIVED DATE: ______________ TIME: ______________	ATTEMPTED TO CONTACT PATIENT DATES: 1.______________ 2.______________ 3.______________	**LEFT MSG**: Y / N Y / N Y / N

☐ Faxed ☐ Mailed ☐ General Counsel
☐ No record found/Letter Sent INITIALS
SEND DATE:______________ _______