

Patient's Name _____ Date of Birth _____

Address _____

I, _____, hereby authorize
FULL NAME OF PATIENT

_____ to release information specified below from my medical records
NAME OF HOSPITAL, PHYSICIAN, SERVICE AGENCY OR THIRD PARTY

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

Purpose for Release: ___ Medical ___ Insurance ___ Legal ___ Other ___

Check off items being released:

- ___ Cardiology
- ___ Clinic Visit
- ___ Hospital Admission
- ___ Abstract ()
- ___ Dictated Letter
- ___ Other _____
- ___ Discharge Summary
- ___ History and Physical
- ___ Consultation Reports
- ___ Surgery/ Pathology Reports
- ___ Laboratory- X-ray
- ___ Immunization Records

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, and psychiatric treatment.

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)

In authorizing the release of the confidential information identified above, I hereby waive all restrictions or privileges imposed by law and release Loyola Student Health Services, Ochsner Clinic Foundation 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.

This authorization may be revoked in writing at any time, except to the extent that Loyola Student Health Services has already taken action in reliance on it. Letters to revoke this authorization should be addressed to Loyola Student Health Services.

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

ADDRESS

DATE SIGNED