LSU Health Healthcare Network
Neurology/Neurosurgery Department
3700 St. Charles Avenue, 4th Floor
New Orleans, LA 70115
Phone: (504) 412-1517
Fax: (504) 412-1518

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____

Patient Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Social Security #: _____ Medical Record #: _____

I _____ hereby authorize the LSU HEALTH HEALTHCARE NETWORK to release any and all of my medical record information to the following firm or individual(s):

_____ at Address or

Fax #: _____

Purpose of Disclosure: _____

Information to Be Used/Disclosed (Be Specific): _____

_____

_____

If I am signing this authorization as the authorized representative of the patient, I am authorized to act on behalf of the patient for the following reason: _____

_____

This authorization may include but is not limited to the release of psychological, psychiatric, alcohol, drug abuse and HIV/AIDS data. This authorization includes reviewing and/or copying all or portions of my medical record. I release LSU HEALTHCARE NETWORK and my physician from any responsibility or liability of releasing this information.

The patient's treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. The patient has the right to revoke the authorization, in writing, at any time by sending such written notification to the address or fax number above. The revocation is not effective to the extent that this facility has taken action in reliance thereon or if the authorization was obtained as a condition of obtaining insurance and a law provides the insurer with the right to contest a claim under the policy.

The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the privacy regulations.

_____ _____

Patient's Signature Date

_____ _____

Witness Date

_____

Authorization Expiration Date