AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL HEALTH INFORMATION

TUCH must obtain a written authorization from a patient or their Personal Representative prior to releasing Confidential 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. All requests should be sent to: **Campus Health, Tulane University, 6823 St. Charles Ave., Bldg. 92, New Orleans, LA 70118** or faxed to **504-865-5083.**

PATIENT AND RECIPIENT'S INFORMATION

I hereby authorize The Administrators of the Tulane Educational Fund d/b/a Tulane University and Tulane University Campus Health to release Confidential Health Information from the records of:

Patient's Information

Name: _____

DOB (MM-DD-YYYY): _____

Splash ID: _____

Phone: _____

TO - Recipient's Information:

Name: _____

Address: _____

Phone: _____

FAX: _____

PURPOSE OF DISCLOSURE

☐ Treatment ☐ Personal ☐ Legal ☐ Academic

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 all that apply*):

___ Progress Notes
___ Doctor's Orders
___ Nurse's Notes
___ Lab Reports
___ CAPS Mental Health Records
___ CAPS Psychotherapy Notes (*If checked, all other records must be requested in a separate authorization.*)
___ Other (Please Describe): _____

___ Results of STD/STI Testing
___ Billing Records
___ Immunization Records
___ Prescription/Medication Records
___ All Campus 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. **This authorization, and in copy thereof, will be deemed revoked once the requested disclosure is made. Subsequent authorizations must be executed for each requested disclosure.**
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 Confidential 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