RIVER OAKS HOSPITAL

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CONSENT AND AUTHORIZATION TO RELEASE INFORMATION

I, _____, Date of Birth _____

request and authorize **River Oaks Hospital**
1525 River Oaks Road West
New Orleans, LA 70123-2199
(504) 734-1740

to release and obtain my medical records or information concerning my medical records to and from:

_____
Name of Person/Organization

_____
Street Address

_____
City/State/Zip Code

_____
Phone Number Fax Number relationship to patient

SPECIFIC EXTENT OF INFORMATION:

Dates of Hospitalization _____

☐ Admission Record	☐ Physical	☐ Alcohol/Drug Usage Info
☐ Consultation Reports	☐ Physician Orders	☐ HIV/AIDS Info
☐ Diagnosis	☐ Progress Notes	
☐ Discharge Summary	☐ Psychiatric Evaluation	☐ Other (Specify) _____
☐ Educational Evaluations	☐ Psychological Tests	
☐ History	☐ Social History	

I understand that I have the right to refuse to disclose HIV test results. ☐ I DO NOT AUTHORIZE release of HIV test results.

REASON FOR RELEASE OF INFORMATION:

I understand that I may revoke this authorization at any time except to the extent that action has been taken by providing a specific request to revoke in writing to the River Oaks Privacy Officer. I further understand that this authorization will be effective on the date signed and will expire on _____ (not to exceed 12 months) and cannot be renewed without my written authorization. (Date)

I understand that this authorization is voluntary and my refusal to sign will not affect my ability to obtain treatment. I understand that I may inspect or copy information to be used or disclosed as provided for by law. I understand that any disclosure of information carries with it the potential for a re-disclosure and that the information may no longer be protected by federal confidentiality laws. If I have questions about disclosure of my health information, I can refer to the program's Notice of Privacy Practices for Protected Health Information or contact the River Oaks Privacy Officer.

To the Party Receiving this Information: This information has been disclosed to you from the records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

For patient records applicable Under Federal Law 42 CFR Part 2 and all other patients.

Signed _____

Date _____

Witness _____

Witness _____

If the above-name person if either under age 16 or has a legally appointed guardian.

Signed _____

Date _____

Please be advised that under the Health Information Portability and Accountability Act of 1996 this Consent and Authorization to Release Information may be denied by your licensed health care professional. However, in the instance of denial, you the patient, possess the right to have the denial reviewed.