OMEGA Hospital

PATIENT LABEL

Authorization to Disclose Health Information

Please follow the following instructions to complete an authorization:

1. Complete all sections on the "AUTHORIZATION TO DISCLOSE OR RELEASE PROTECTED HEALTH INFORMATION" form. Incomplete forms will not be accepted (mandated by the Federal Guidelines for HIPAA.)

2. The form must be completed by the patient or authorized patient representative, with appropriate identification.

3. If patient is deceased, did not expire at this facility, and you are the next of kin, please include a copy of the death certificate.

4. Please send (mail, fax, or email) your completed Authorization to Release Protected Health Information to the appropriate location listed on the authorization form.

5. If you have any questions regarding the release of your medical information, please contact the Health Information Management Department at (504) 832-4200.

6. The authorization will terminate on the date indicated on the Authorization or when revoked in writing by the patient.

7. Due to the volume of requests, Omega Hospital contracts with a 3rd party vendor to assist with Medical Record Requests, MRO Corporation.

- Service Charge:

  Paper: $0.10/page plus tax and postage

  Electronic: $0.10/page

- Electronic Delivery or CD: Flat fee of $6.50

OMEGA Hospital

PATIENT LABEL

Authorization to Disclose Health Information

Patient Information (Please PRINT)

First Name:	Last Name:
Middle Initial:	Date of Birth: / / (MM/DD/YYYY)
Street Address:	
City: State:	Zip Code:
Home Phone Number: ( )	Cell Phone Number: ( )
Email address (optional):	

I hereby authorize:	
☒ **Omega Hospital** **2525 Severn Avenue** **Metairie, LA 70002**	Phone Number: (504) 849-4871 Fax Number: (504) 832-4209 Email: medicalrecords@omegahospital.com

To (Check ONE): ☐ To receive information from ☐ To release information to: ☐ Myself (see info above)

Name:

Street Address:

City: State: Zip Code:

Telephone Number: ( ) Fax Number: ( )

Health Information to be used and/or disclosed under this authorization. **Date of Service:**

☐Abstract ☐ Complete Health Record
☐History & Physical ☐ Operative Report ☐ Discharge Summary
☐Pathology/Lab Reports ☐ Radiology Reports ☐ Radiology Films/Images ☐ Itemized Bill

The below information will **NOT** be released unless you specifically authorize by initialing below:
AIDS or HIV test results: _____ Behavioral Health Information: _____ Alcohol/Substance abuse treatment_____

Purpose of the use and/or disclosure (Check ONE): "At my request" is a sufficient purpose for a patient initiating this request)
☐ Continued Care ☐Legal ☐Insurance ☐At my request ☐Other:

Acknowledgement of Understanding:

- I understand that I may withdraw my authorization in writing at any time except to the extent that action has been taking in reliance on this statement. Withdrawal must be made in writing and presented or mailed to the Health Information Management Department at the address listed above.
- I understand that this authorization statement will expire in **one year from the date** signed unless I identify a different date: _____; whichever is sooner.
- I understand that if I do not sign this form, my health care and the payment of my health care will not be affected.
- I understand that signing this form is voluntary. Omega Hospital may not condition treatment, payment, enrollment in health plans, or eligibility for benefits on my signing or refusal to sign this authorization, except in limited circumstances.
- I understand that once Omega Hospital discloses my PHI to the receipt, Omega Hospital cannot guarantee that the recipient will not redisclose my PHI to a third party. The third party may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of my PHI.
- I understand that I may inspect or copy the information to be used or disclosed, as provided by 42 CFR 164.524
- I understand that there is a charge for photocopies and records provided on electronic media, as permitted by Louisiana law, unless copies are sent directly to another healthcare provider.
- I understand the record might not be complete, if it is a recent visit, and additional documentation could be added after submitting.

Signature of patient or Legal Representative: Date:

Printed Name of patient or Legal Representative: Relationship to Patient:

Representative's Authority to Act for Patient: (***Attach supporting documentation***)