Campus Health
TULANE UNIVERSITY

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: by mail to **Campus Health, Tulane University, 6823 St. Charles Ave., Bldg. 92, New Orleans, LA 70118**, by fax to **504-865-5083**, or by email to **CHMedRecords@tulane.edu.** *A staff member may call you at the number you list below to clarify your request.

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 of the patient listed below.

THE RECORDS OF: *(Patient's Information)*

Name: _____

DOB (MM-DD-YYYY):_____ Splash ID:_____

Address: _____

Phone: _____

DELIVER TO: *(Recipient's Information)*

Name: _____

Address: _____

Email: _____

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 only those that apply or select All Records.)*

Medical Records

- ☐ Progress Notes
- ☐ Results of STD/STI Testing
- ☐ Doctor's Orders
- ☐ Billing Records
- ☐ Nurse's Notes
- ☐ Lab Reports
- ☐ Immunization Records
- ☐ Prescription/ Medication Records
- ☐ Other (Please Describe): _____ _____

Mental Health Records

- ☐ CAPS Mental Health Records *(Appointment history, diagnosis, psychiatric prescriptions, progress to date)*
- ☐ CAPS Psychotherapy Notes (*If checked, all other records must be requested in a separate authorization.*)
- ☐ Please Describe (if needed): _____

All 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

OFFICE USE ONLY

RECEIVED DATE: _____ TIME: _____	ATTEMPTED TO CONTACT DATES: **LEFT MSG**: 1._____ Y / N 2._____ Y / N 3._____ Y / N	**CLARIFY WITH STUDENT DATE:** _____ STAFF INITIALS: _____

☐ Faxed ☐ Mailed ☐ General Counsel ☐ Emailed ☐ Secure Msg ☐ Picked Up
☐ No record found/Letter Sent INITIALS
SEND DATE:_____ _____