Authorization to Release or Obtain Protected Health Information (PHI)

LSU Student Health Center | Our Lady of the Lake Health

Medical Records • FAX: 888-837-2271 • MEDICALRECORDS@LSU.EDU
Mental Health Service • FAX: 888-837-2598 • MHS@LSU.EDU

1 I AUTHORIZE THE FOLLOWING PROTECTED HEALTH INFORMATION TO BE RELEASED FROM THE HEALTH RECORD OF:

Patient Last Name | Patient First Name | Date of Birth (MM/DD/YYYY)

E-mail Address | LSU ID# | Phone Number

Street Address | City | State | Zip

2 This Authorization allows the Student Health Center to: (check one or both)

☐ RELEASE copies of your record to (or discuss your information with) the provider/person/facility below

☐ OBTAIN copies of your record from (or discuss your information with) the provider/person/facility below

Name of Provider/Person/Facility _____ Address _____

City, State, Zip Code _____ Phone # / Fax # (include area code) _____

Check one (or two): ☐ **Mail Records** ☐ **Fax Records** ☐ **Pick Up** ☐ **Discuss Verbally** ☐ **E- Mail** (I would like to receive my records via encrypted email.)

3 INFORMATION TO BE RELEASED *Covering the periods of care from:* _____ *to* _____
MM/DD/YYYY MM/DD/YYYY

HEALTH INFORMATION

- ☐ Chart Note(s)
- ☐ Laboratory Results
- ☐ X-Ray Report
- ☐ Immunization Report
- ☐ ADHD Testing and Chart Note(s)
- ☐ Pharmacy Records
- ☐ Itemized Billing Statement(s)
- ☐ Other:_____

MENTAL HEALTH INFO. CONTENT

- ☐ Treatment Summary _____
- ☐ Diagnosis _____
- ☐ Psychiatric Summary _____
- ☐ Verification of dates of attendance of sessions
- ☐ Other _____

4 PURPOSE OF DISCLOSURE: ☐ **Health Care** ☐ **Legal** ☐ **Insurance** ☐ **Personal** ☐ **Other** _____

5 SENSITIVE INFORMATION RECORDS RELEASE ***The following info. will be released when included in the health or billing record unless you indicate otherwise:***

- ☐ **Do not release AIDS/HIV or any STD test results**
- ☐ **Do not release any records of psychiatric care or mental health information**
- ☐ **Do not release any records of alcohol/drug/substance abuse**
- ☐ **Do not release any records of genetic testing**

6 EXPIRATION DATE ***Unless revoked, or otherwise specified, this authorization will expire one year from the date of signature:*** _____

7 I UNDERSTAND THE FOLLOWING:

- *Except to the extent that action has already been taken in reliance on this authorization, this authorization may be revoked at any time by submitting a written notice to the Privacy Officer, LSU Student Health Center,16 Infirmary Lane, Baton Rouge LA 70803.*
- *The information disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996.*
- *I may refuse to sign this authorization and that it is strictly voluntary. Louisiana law requires a written authorization in order to release Protected Health Information (PHI) to a third party.*
- *My right to healthcare treatment and the payment for my healthcare is not conditioned on this authorization, unless disclosure or use of the information is necessary for treatment.*
- *I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.*
- *If I am selecting to have documents sent by encrypted email, I acknowledge that you cannot guarantee the confidential security of the transmission of information.*

8 I UNDERSTAND AND AUTHORIZE THIS RELEASE

Print Name of Patient or Legal Representative _____ **Date** _____

Signature of Patient or Legal Representative _____ **Relationship to Patient** _____

Revised: June 2025

ALL SECTIONS ARE REQUIRED. MUST PROVIDE PHOTO ID PRIOR TO RELEASE OF INFORMATION.