CHILDREN'S HOSPITAL

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

All areas designated by an ➡ are REQUIRED for valid authorization.

PLACE PATIENT'S LABEL HERE

1 *I authorize* ➡ NAME OF HOSPITAL / PHYSICIAN: **Children's Hospital, New Orleans /** ☑ *to receive from* ☑ *to release to*

INFORMATION REGARDING:

2 SPECIFIC NAME OF HOSPITAL, PHYSICIAN, SERVICE AGENCY OR THIRD PARTY: Jeffrey Thomas Bodin

3 ➡ STREET ADDRESS: 528 Beau Chene Dr | CITY: Mandeville | STATE: LA | ZIP CODE: 70471

☑ *Mail* ☑ *Email :* jeffreybodin713@gmail.com

Patient's Name: Jeffrey Thomas Bodin

Patient's Date of Birth: 05/22/1997

Service Dates: 01/01/2008 - 01/01/2019

4 ➡ *I AUTHORIZE THE RELEASE OF THE FOLLOWING INFORMATION:*

☑ Abstract (H&P, OP, DS, Rad, Lab, Con)	☑ Complete Hospital	☑ History and Physical Report (H&P)
☑ Adolescent Behavioral Health	☑ Consultation(s) (Con)	☑ Lab Reports (Lab)
☑ Audrey Hepburn CARE Center	☑ Diagnosis, including alcohol and drug abuse	☑ Radiology Results (Rad)
☑ Billing Information	☑ Discharge Summary (DS)	☑ Results of HIV testing
☑ Clinic Notes	☑ Emergency Room Record (ER)	☑ Report of Operation (OP)
☑ Complete Clinic Reocrd		
☑ Other: Any records relating to cancer treatment 2008.		

5 ➡ *I AUTHORIZE the release of HIV test results. I understand I am authorized by law to allow or refuse to allow the release of HIV Test Results. An HIV Test Result is the original document, or copy thereof, transmitted to the medical record from the laboratory or other testing site with the result of an HIV-related test. It does not include any other note, notation, diagnosis, report, or other writing or document.*

☑ **I AUTHORIZE** the release of HIV test results. ☐ **I DO NOT AUTHORIZE** the release of HIV test results.

This information is to be released for the purpose of:

6 ➡

☐ Continuation of care ☐ Treatment in the facility indicated above ☐ Legal services ☐ Academic Case Study/Journal Story
☐ Insurance request ☑ Other (please specify purpose) Records Purposes

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the medical records department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in one year.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 42.164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the hospital's Privacy Officer.

7 ➡ *Signature(s) & Date(s) Required*

Patient, Parent/Guardian of Minor or Legal Representative Signature X Jeffrey Bodin		**Phone Number** Home / Cell (985) 520-4713 / (985) 272-8989
Relationship to Patient or Title of Legal Representative	**Date** MM/DD/YY / /	**Time** 00:00 am/pm : AM PM
Witness Signature X	**Date** MM/DD/YY / /	**Time** 00:00 am/pm : AM PM

☑ *Electronic Media Requested* ☐ *Language Line:* ☐ *Declined* ☐ *Interpreter's #* _____

☐ *CD Processed Name:* _____ *Date:* _____

☐ *Scan to PT Auth*

RELEASE OF INFORMATION
Authorization for Records

RI0020

NUMBER(S) 2 & 3

THE NAME AND ADDRESS OF THE PERSON WE ARE MAILING (RELEASING) THE RECORDS TO

4

PLEASE CHECK OFF THE INFORMATION YOU ARE AUTHORIZING CHILDREN'S TO RELEASE

#5

PLEASE CHECK OFF THE PURPOSE OF THE REQUEST.

(YOU CAN CHECK OFF OTHER AND PUT PERSONAL OR ANY OTHER REASON)

PLEASE INCLUDE A COPY OF YOUR ID AND MAKE SURE THE AUTHORIZATION IS FILLED OUT COMPLETELY.

MAIL YOUR AUTHORIZATION TO:

CHILDREN'S HOSPITAL

C/O MEDICAL RECORDS

200 HENRY CLAY AVE.

NEW ORLEANS, LA. 70118

OR E-MAIL TO

CHMROStaff@lcmchealth.org

MRO

888.252.4146
sales@mrocorp.com
www.mrocorp.com

MRO is the company that handles release of medical records for Children's Hospital. As their partner for Release of Information (ROI), it is our pleasure to serve you!

Please fill out an ROI authorization form, and be sure to sign and date it. Patients and their Personal Representatives requesting copies of the patient's records do not need to provide a purpose or an expiration date for their request.

The processing time for copies of records is 5-7 business days after receipt of payment, depending on the type of records and the dates of service requested. Federal law permits Children's Hospital to assess patients a reasonable, cost-based fee for copies of their records. (See 45 CFR § 164.524(c)(4).)

For copies of your records, you may be assessed a fee based on the following fee schedule:

How the PHI is Maintained	Requested Format of PHI	Reasonable, Cost-Based Fee
Electronically	Electronic (Email or CD-ROM)	Flat fee of $6.50 (inclusive of actual labor, supplies and postage), plus applicable sales tax
Electronically	Paper	$0.10 per page ($0.08 per page for actual labor and $0.02 per page for supplies), plus applicable postage and sales tax
Paper	Paper	$0.10 per page ($0.08 per page for actual labor and $0.02 per page for supplies), plus applicable postage and sales tax
Paper	Electronic (Email)	$0.08 per page (actual labor), plus applicable sales tax
Paper	Electronic (CD-ROM)	$0.08 per page (actual labor), plus $0.22 per CD-ROM/ Mailer (supplies), plus applicable postage and sales tax
Hybrid – Electronic and Paper	Paper	$0.10 per page ($0.08 per page for actual labor and $0.02 per page for supplies), plus applicable postage and sales tax
Hybrid – Electronic and Paper	Electronic (Email and CD-ROM)	Flat fee of $6.50 (inclusive of actual labor, supplies and postage), plus applicable sales tax

Once the records are ready, you will be notified via mail. Please review the invoice for payment information. Payment may be made by check, credit card or money order. Your requested records will then be mailed to you.

Prices are subject to change.

Please call 610.994.7500 Ext. 1 to check the status of your request, make a payment or ask any questions.