University Medical Center New Orleans
LCMC Health

AUTHORIZATION TO DISCLOSE OR RELEASE PROTECTED HEALTH INFORMATION

PAGE 1 OF 1

BODIN, JEFFREY
CSN: 600073319783
DOB: 5/22/1997 (22 yrs) Male
MRN: 1002548110
Adm Date: 11/5/2019

Patient Information (Please PRINT)

First Name: Jeffrey	Last Name: Bodin
Middle Initial: Thomas	Date of Birth: 05 / 22 / 1997 (MM/DD/YYYY)
Street Address: 528 Bean Chene Dr	
City: Mandeville	State: LA — Zip Code: 70471
Home Phone Number: (985)520-4713	Cell Phone Number: (985) 272-8989
Email address (optional): jeffreybodin713@gmail.com	

I hereby authorize (check ONE):	Address:	
☑ University Medical Center New Orleans (UMCNO)	*Attention: Release of Information*	Phone Number: (504) 702-2082
☑ UMC Clinics	2000 Canal Street	Fax Number: (855) 526-9216
Physician Name: Dr Lindon	New Orleans, LA 70112	Email address: UMCMedicalRecords@lcmchealth.org
Clinic Name:		

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

Name: Dr Kevin McLaughlin	
Street Address: 350 Lakeview Dr	
City: Covington	State: LA — Zip Code: 70433
Telephone Number: (985) 845-2677	Fax Number: (985) 867-5498

Health Information to be used and/or disclosed under this authorization:

Dates of Service: Start Date: All dates End Date: Present

☑ Abstract	☑ Complete Health Record	☑ Itemized Bill	☑ Progress / Clinic Notes
☑ AVS – After Visit Summary	☑ Discharge Summary	☑ Immunization Records	☑ Radiology Reports
☑ Autopsy Report	☑ Emergency Room Record	☑ Operative Report	☑ Radiology Films / Images
☑ Cardiology Reports	☑ History and Physical	☑ Pathology / Lab Reports	
☑ Other:			

The below information will **NOT** be released unless you specifically authorized by initialing below:

AIDS or HIV test results:	JTB	Behavioral Health Information:	JTB
Alcohol/substance abuse treatment:	JTB	Genetic Testing:	JTB

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. LCMC Health 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 LCMC Health discloses my PHI to the recipient, LCMC Health 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 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: Jeffrey Bodin	Date: 2019-11-05
Printed Name of Patient or Legal Representative: Jeffrey Bodin	Relationship to Patient:
Representative's Authority to Act for Patient: *(Attach supporting documentation)*	

HIM ROI AUTHORIZATION
LC-UM2500-E | (07/19) New

*PL116 *

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Clinic Name:			

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

Name: Children's Hosp Hematology and Oncology (Dr. Dana LeBlanc)		
Street Address: 200 Henry Clay Ave		
City: New Orleans	State: LA	Zip Code: 70118-5720
Telephone Number: (504) 896-9740	Fax Number: (504) 896-3994	

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