One mailing address for all facilities:
LSU Healthcare Network Release of Information
3700 St. Charles Ave, 1st Floor, Room 115, New Orleans, LA 70122
504-412-0151

LSUHealth Healthcare Network

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

(From non-LSU Healthcare Network facility - To LSU Healthcare Network facility)

Patient Name (Last, First, Middle):	Date of Birth:	SSN:	LSUHN Chart #:

Address:	Telephone #:

RELEASE FROM: Please provide Name/Address of person/organization from which disclosure is to be made

Name:	Address:	Phone:	Fax:

DATES OF SERVICE to be released: _____ **(Specify dates –this line MUST BE completed)**

☐ Continuing Care/Treatment ☐ Personal ☐ Legal ☐ Applying for Social Security Disability
☐ Daycare/School ☐ Insurance ☐ Other (please specify): _____

Release/Fax To:

☐ Uptown –St Charles
3700 St. Charles Ave.
New Orleans, LA 70115

☐ Uptown-McFarland Bldg.
4429 Clara St., #340
New Orleans, LA 70115

☐ Kenner
200 W. Esplanade Ave.
Kenner, LA 70065

☐ Metairie Multi-Specialty
4228 Houma Blvd.
Metairie, LA 70006

☐ Behavioral Health
3450 Chestnut St., 3rd Flr
New Orleans, LA 70115

☐ Westbank-Gretna
120 Meadowcrest St.
Suite 340
Gretna, LA 70056

☐ Westbank
4500 10th St.
Suite B & C
Marrero, La

☐ Village De Jardin
8801 Lake Forest Bldg.
Bldg. 11
New Orleans, LA 70127

☐ Terraces on Tulane
Primary Care
3615 Tulane Ave
New Orleans, LA 70119

☐ Baton Rouge
8585 Picardy Ave
Suite 313
Baton Rouge, LA 70809

☐ Lafayette
2390 W. Congress St
Lafayette, LA 70506

Select Portions of Protected Health Information to be released:

☐ Complete Health record ☐ Office Notes ☐ X-Ray films/Reports
☐ Complete Billing Record ☐ Laboratory Test/Results
☐ Psychotherapy Notes ☐ Other:_____

Drug and/or Alcohol Abuse, and/or Psychiatric, and /or HIV/AIDS Record Release

I understand if my medical or billing records contain information referencing drug and/.or alcohol abuse, psychiatric care, sexually transmitted disease, hepatitis B or C testing, and/or other sensitive information, I agree to its release. Check One: ☐ **YES** ☐ **NO**

I understand if my medical or billing record contains information referencing HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release. ☐ **YES** ☐ **NO**

Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, the authorization may be revoked at any time by submitting a written notice to LSU Healthcare Release of information/Medical Records. Unless revoked, this authorization will expire 12 months from the date of signature or 90 days for psychotherapy, drug and/.or alcohol abuse, psychiatric care, sexually transmitted disease, hepatitis B or C testing.

Signature of Patient or Personal Representative Who May Request Disclosure

1. I, the undersigned, have read the above and authorize LSU Healthcare Network to disclose such information as herein contained.
2. I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form. However, if health care services are being provided to me for the purpose of providing information to a third-party (e.g. Fitness-for-work test). I understand that services may be denied if I do not authorize the release of information related to such health care services to third-party.
3. I understand, I can inspect or copy the protected health information to be used or disclosed.
4. I hereby release and hold harmless LSU Healthcare Network from all liability and damages resulting from the lawful release of my Protected Health Information.

_____ _____ _____

Date **Signature of Patient/Parent/Conservator/Guardian** **Authority/Relationship to Patient**

LSUHealth
Healthcare Network

Authorization for Use or Disclosure of Protected Health Information

I authorize my physician and/or administrative and clinical staff of the LSU Healthcare Network, to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices of the LSU Healthcare Network.

Name and relationship of person you wish to allow access - for example, your spouse, child, sibling, neighbor, caretaker, clergy, or close friend:

Name of Person or Entity **Relationship**

_____

_____

_____

_____

_____

_____

This authorization to use and disclose this protected health information is being submitted by my request and shall be in force and effect until revoked in writing by me, or, if the purpose of the disclosure is related to research, at the end of the research study.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the LSU Healthcare Network and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the LSU Healthcare Network's Privacy Officer at the Health Information Management Department. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

Regardless of whether you provide us with this authorization, we will provide you with medical services or conduct payment operations. However, if your treatment is for any of the following purposes, we have the right not to provide you with medical services:

1. If your treatment is related to research
2. If health care services are provided to you solely for the purpose of creating protected health information for disclosure to a third party

_____
Patient's Signature or Personal Representative

_____
Date

_____
Print Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

Send correspondence to:

LSU Healthcare Network
Attn: Health Information Management Department
1542 Tulane Ave., Room 235 L
New Orleans, LA 70112

LSUHealth
Healthcare Network

PATIENT INFORMATION

Name (Last, First, Middle Initial):

Salutation: ◯ Mr. ◯ Miss ◯ Mrs. ◯ Ms.

Marital status: ◯ Single ◯ Married ◯ Divorced ◯ Separated ◯ Widowed

Social Security #

Preferred Language:

Race:
◯ American Indian or Alaska Native
◯ Asian
◯ Black or African American
◯ Caucasian or White
◯ Native Hawaiian or Other Pacific Islander
◯ Other
◯ Unknown

Ethnicity:
◯ Hispanic or Latino
◯ Not Hispanic or Latino
◯ Unknown

Date of Birth:

Gender: ◯ Male ◯ Female

Street Address:

City:

State and Zip Code:

Home Phone #:

Work Phone #:

E-mail Address:

Cell Phone #:

Occupation:

Employer:

How did you hear about us? (Please check one box):

◯ Physician: _____ ◯ Family/Friend ◯ Health Fair ◯ Newspaper / Radio ◯ TV ◯ Telephone directory ◯ Web Site: _____ ◯ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):

Relationship to Patient:

Home Phone #: ( )

Work Phone #: ( )

INSURANCE INFORMATION

(Please give your insurance card(s) to the receptionist.)

Primary Insurance Carrier:

Primary Policy Holder's Name:

Patient Relationship to Policy Holder:

Policy #:

Group #:

Policy Holder's Social Security #:

Policy Holder's Date of Birth:

Name of Secondary Insurance (if applicable):

Secondary Policy Holder's Name:

Secondary Group #:

Secondary Policy #:

Primary Care Physician and Pharmacy

Primary Physician:

Referring Physician:

Preferred Pharmacy and Address:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize LSU Healthcare Network or insurance company to release any information required to process my claims.

Authorization to Release Medical Information: I hereby authorize my Provider to release any information necessary for my course of treatment.

Consent for Examination: I hereby consent to such examination procedures, as in the judgment of my physicians, may be considered necessary or advisable while a patient at the LSU Healthcare Network ("LSUHN"). I recognize that LSUHN manages teaching and research facilities, and that my treatment and care will be observed and in some instances aided by physicians and/or technicians under supervision.

Patient/Guardian signature:

Date:

1542 Tulane Ave., Suite 123HCN ◆ New Orleans, Louisiana 70112 ◆ (504) 412-1100

Patient Name_____ Date of Birth_____

Allergies: Medications, Environmental, & Food:

Allergies:	Reaction:	Date:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications:

Please list all current medications and dosages:

Medications:	Dosages:	Medications:	Dosages:

Surgeries/Operations:

Please list dates of all surgeries and operations:

Please print a preferred pharmacy:

(Name and General Location)

_____

LSUHealth Healthcare Network

Patient Name:_____ Date of Birth:_____

Medical History:

Diagnosis	**Your** Past Medical History	**Family's** Past Medical History	Family Member
Alcoholism	◯ Yes ◯ No	◯ Yes ◯ No	
Anemia	◯ Yes ◯ No	◯ Yes ◯ No	
Arthritis	◯ Yes ◯ No	◯ Yes ◯ No	
Asthma	◯ Yes ◯ No	◯ Yes ◯ No	
Blood Clot	◯ Yes ◯ No	◯ Yes ◯ No	
Breast Cancer	◯ Yes ◯ No	◯ Yes ◯ No	
Colon Cancer	◯ Yes ◯ No	◯ Yes ◯ No	
Prostate Cancer	◯ Yes ◯ No	◯ Yes ◯ No	
Other Cancers:	◯ Yes ◯ No	◯ Yes ◯ No	
COPD	◯ Yes ◯ No	◯ Yes ◯ No	
Depression	◯ Yes ◯ No	◯ Yes ◯ No	
Diabetes	◯ Yes ◯ No	◯ Yes ◯ No	
Drug Abuse	◯ Yes ◯ No	◯ Yes ◯ No	
Eczema, Hives, Rash	◯ Yes ◯ No	◯ Yes ◯ No	
Epilepsy	◯ Yes ◯ No	◯ Yes ◯ No	
Glaucoma	◯ Yes ◯ No	◯ Yes ◯ No	
Heart Attack	◯ Yes ◯ No	◯ Yes ◯ No	
Heart Disease	◯ Yes ◯ No	◯ Yes ◯ No	
High Blood Pressure	◯ Yes ◯ No	◯ Yes ◯ No	
High Cholesterol	◯ Yes ◯ No	◯ Yes ◯ No	
Stroke	◯ Yes ◯ No	◯ Yes ◯ No	
Thyroid Problems	◯ Yes ◯ No	◯ Yes ◯ No	
Other	◯ Yes ◯ No	◯ Yes ◯ No	

LSU Health Healthcare Network

Patient Name:_____ Date of Birth:_____

Social History:

Do you have any children? : Yes No How many? _____

Names and Dates of Birth:

_____ _____

_____ _____

_____ _____

Do you drink alcoholic beverages? ◯ Yes ◯ No

Beer ☐ Wine ☐ Liquor ☐ (Circle all that apply)

Do you use tobacco? ◯ Yes ◯ No

Cigarettes ☐ Cigars ☐ Chewing tobacco ☐ (Circle all that apply)

How often? _____ Have you ever stopped? ◯ Yes ◯ No When? _____

Do you use illicit drugs? ◯ Yes ◯ No

Marijuana ☐ Cocaine ☐ Prescription Drugs ☐ Other:_____

Immunization History: Please list dates

Tetanus Injection	
Flu Injection	
Pneumonia Injection	
Hepatitis B	
Gardisil (HPV Vaccine)	

Health Maintenance: Please list dates

Colonoscopy	
Last Mammogram	
Last Pap Smear	
PSA/Prostate Test	
Dexascan/Bone Scanning	

I have been provided with and reviewed the "Patient's Rights and Responsibilities Pamphlet" and understand my responsibilities as a patient of LSU Healthcare Network (LSUHN). I also understand that should I choose **not** to uphold my responsibilities, LSUHN has the right to delay or reschedule my appointment until my responsibilities are met.

I have also reviewed the LSUHN's Notice of Privacy Practices.

Date: _____

Patient Name: (Please Print) _____

Patient Date of Birth: _____/ _____/ _____

Patient/ Guardian Signature: _____

Relationship to Patient: _____

Comments: _____

_____

_____

_____

_____

To be completed by staff:

Employee Witness: _____

Sent to scanning date: _____

1542 Tulane Avenue
Suite 123-HCN
New Orleans, LA 70112

P 504.412.1100
F 504.412.1406

LSU Health NEW ORLEANS

School of Nursing • HealthCare Network Clinic

Supplemental Intake Form

Patient Last Name: _____

1. Are you a veteran of the United States Military?
   - ☐ Yes
   - ☐ No

2. Please answer the following questions.
   a. How many persons currently live in your household including yourself? _____
   b. What is your current income level of your total household? Check the answer that best pertains to you.
      - ☐ $0 to $15,000
      - ☐ $15,001 to $30,000
      - ☐ $30,001 to $60,000
      - ☐ $60,001 and above
      - ☐ Prefer not to answer