Tulane University Medical Group

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Tulane University Medical Group must obtain a written authorization from a patient or their Personal Representative prior to releasing Protected 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.

PATIENT AND RECIPIENT'S INFORMATION

I hereby authorize Tulane University Medical Group to release Protected Health Information on the patient listed below.

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

Name: _____

DOB (MM-DD-YYYY): _____

Address: _____

Phone: _____

DELIVER TO: *(Recipient's Information)*

Name: _____

Address: _____

Phone: _____

Fax: _____

PURPOSE OF DISCLOSURE

☐ Treatment ☐ Personal ☐ Legal ☐ Insurance

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
☐ Doctor's Orders
☐ Billing Records
☐ Nurse's Notes
☐ Lab Reports
☐ Immunization Records
☐ Other Medical Records:

(Please Describe) _____

_____

_____

Mental Health Records

☐ Mental Health Records
☐ Psychotherapy Notes

*This is the only item you may request on this authorization. You must submit another authorization for other items requested.

All Records

☐ 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.
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 Protected 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 PATIENT DATES: **LEFT MSG**:

1. _____ Y / N
2. _____ Y / N
3. _____ Y / N

☐ Faxed ☐ Mailed ☐ General Counsel
☐ No record found/Letter Sent INITIALS
SEND DATE: _____ _____

Tulane University

Notice of Privacy Practices

TULANE UNIVERSITY MEDICAL GROUP
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received a copy of the Tulane University Medical Group Notice of Privacy Practices.

Signature_____Date_____

Print Patient's Name_____

If not signed by the patient, please indicate relationship:_____

Print Name_____ Witness_____

Tulane University Medical Group
CONSENT AND RELEASE

ASSIGNMENT OF BENEFITS: I authorize direct payment to Tulane University Medical Group (TUMG), of all medical benefits, settlements, or judgments applicable to my treatment by TUMG physicians and other clinicians at the hospital or clinic. This authorization is applicable to all future charges and fees from, and including, this day forward, unless revoked in writing by me. I understand that I am personally responsible for payment of all fees applicable to my treatment by TUMG physicians at the hospital or clinic, including copayments, deductibles, and fees for non-covered services, irrespective of other insurance coverage or other parties' responsibility to me for such fees. If unpaid balances are overdue and are referred for collection, I agree to pay the attorney's fees, court costs, and/or collection agency fees associated with collection.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING, IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT TO EXECUTE THE ABOVE, ACCEPTS THE TERMS THEREOF, AND HAS RECEIVED A COPY THEREOF.

RELEASE OF INFORMATION: I authorize TUMG and/or its physicians and other clinicians to disclose all or part of my medical or billing records to any insurance carrier or persons employed by such carrier for the purpose of collecting insurance benefits and auditing claims, so long as I am listed on this account as having coverage with such carrier. This authorization includes release of information to group health plans for group insurance coverage, workman's compensation carriers, and welfare agencies, if applicable to my claim for treatment. I hereby indemnify and release TUMG and its physicians and clinicians from any and all responsibility relative to the release of such information. Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or healthcare industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records: decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations.

_____ PATIENT NAME

_____ DATE OF BIRTH

_____ PATIENT SIGNATURE

_____ NAME OF AUTHORIZED AGENT, IF ANY

_____ SIGNATURE – IF SIGNED BY AUTHORIZED AGENT

_____ RELATIONSHIP TO PATIENT

_____ WITNESS NAME

_____ WITNESS SIGNATURE

_____ DATE OF SIGNING TIME

RX ELIGIBILITY CONSENT - By signing this consent form you are agreeing that Tulane University Medical Group can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes. I hereby provide informed consent to Tulane University Medical Group to enroll me in the ePrescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

INITIAL _____

CONSENT FOR TREATMENT DATE _____ TIME _____

I, OR _____ FOR _____ KNOWING THAT (I AM/HE OR SHE IS) SUFFERING FROM A CONDITION REQUIRING DIAGNOSIS AND/OR MEDICAL OR SURGICAL TREATMENT, DO HEREBY VOLUNTARILY CONSENT TO SUCH DIAGNOSTIC PROCEDURES AND HOSPITAL, MEDICAL, AND SURGICAL CARE AS NECESSARY IN THE JUDGMENT OF PHYSICIAN(S) IN CHARGE. I AM AWARE THAT THE PRACTICE OF MEDICINE AND SURGERY IS NOT AN EXACT SCIENCE, AND I ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE ME AS TO THE RESULTS OF EXAMINATION OR TREATMENT. I HEREBY AUTHORIZE TULANE UNIVERSITY MEDICAL GROUP TO RETAIN OR DISPOSE OF ANY SPECIMENS OR TISSUES TAKEN FROM MY BODY DURING MY TREATMENT, AND TO USE SUCH SPECIMENS OR TISSUES FOR SCIENTIFIC, EDUCATIONAL, OR RESEARCH PURPOSES, TO THE EXTENT THAT SUCH SPECIMENS AND TISSUES ARE NOT KEPT AT TULANE UNIVERSITY HOSPITAL AND CLINIC.

WITNESS _____ SIGNATURE _____
(PATIENT OR PERSON AUTHORIZED TO CONSENT RELATIONSHIP)

REFUSAL OF CONSENT FOR TREATMENT

I, _____ REFUSE TO CONSENT TO _____

_____ UPON _____

_____ I HAVE BEEN ADVISED OF THE CONSEQUENCES AND RISKS OF SUCH REFUSAL, AND HEREBY RELEASE THE PHYSICIANS, CLINICIANS, AND TULANE UNIVERSITY MEDICAL GROUP FROM LIABILITY FOR INJURIES ARISING FROM SUCH REFUSAL.

WITNESS _____ SIGNATURE _____
(PATIENT OR PERSON AUTHORIZED TO CONSENT RELATIONSHIP)

Specialty Care - Metairie
2800 Veterans Boulevard, Suite 140
Metairie, Louisiana 70002
P 504-988-0501 F 504-988-0502

New Patient - Demographics Information

Patient Name _____ Date _____/_____/_____

Address_____
Street City Zip

Age _____ Date of Birth _____/_____/_____ Birth Sex: ☐ Male ☐Female

Race_____ Ethnicity_____

Marital Status: ☐Married ☐Single ☐Partnered ☐Widowed ☐Divorced ☐Legally Separated

Preferred Name _____ Email _____

Primary phone number (_____) _____-_____ ☐Cell ☐Home ☐Work

Secondary phone number (_____) _____-_____ ☐Cell ☐Home ☐Work

Preferred method of communication _____

Primary Insurance _____

Subscriber #/Member ID: _____ Policy Holder ☐Self ☐Other_____

Group Name _____ Group # _____

Secondary Insurance ☐Yes ☐No _____

Interpreter needed ☐Yes ☐No If so, Language spoken: _____

Primary Care Physician_____ Referring MD_____

Chief complaint/Reason for appointment: _____

How did you hear about us? ☐Referred by MD ☐Family/Friend ☐Insurance Company ☐Social Media ☐Mail ☐Online ☐Magazine ☐TV ☐Radio ☐Other _____

Preferred Days For Appointment: ☐Monday ☐Tuesday ☐Wednesday ☐Thursday ☐Friday

Preferred Time: ☐Morning ☐Afternoon Day/Time conflicting with your schedule _____

Times and days of appointments offered are dependent on MD schedule. This is strictly a preference.
We will do our best to accommodate you as much as possible according to your needs.

Tulane Doctors

Tulane Heart and Vascular/Tulane Family Medicine

Dr. Hendel Dr. Anwar Dr. Sander Dr. Wanna Dr. Cartwright Dr. Sweeney / Dr. Wartenberg