

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

Tulane University Student Health Center
New Orleans, LA 70118-5698

REC 002 APPENDIX I

PRIMARY CARE MAIN NUMBER: (504) 865-5255
PRIMARY CARE FAX: (504) 865-5083
PSYCHIATRY FAX: (504) 865-5770
WOMEN'S HEALTH FAX: (504) 862-8914

I hereby authorize:

_____ (complete name of facility releasing the information)

_____ address (if other than above)

to disclose to:
address above

_____ (name and address of person/facility to which disclosure is to be made)

copies of the following medical information contained in my medical records:

- | | | |
|--|---|--|
| <input type="checkbox"/> Immunization Record | <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Consultation Form |
| <input type="checkbox"/> Pap Smears | <input type="checkbox"/> EKG | <input type="checkbox"/> Verbal Information to Parties Above |
| <input type="checkbox"/> History & Physical Exam | <input type="checkbox"/> EEG | <input type="checkbox"/> Letters to Deans/Professors |
| <input type="checkbox"/> Medication Records/Summary Sheet | <input type="checkbox"/> Radiology Report | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Psychiatric/Psychological Evaluations | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Allergy Records |
| <input type="checkbox"/> Other _____ | | |

I, the undersigned, understand that I may revoke this consent at any time, except to the extent that action has already been taken in reliance on it. This consent will expire upon completion of the transaction and no later than ninety (90) days from the date signed, unless otherwise stated herein.

To the party receiving this information: This information has been disclosed to you from the records whose confidentiality is protected by federal law. Federal Regulations may prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

Signature of Patient

Printed name

Social Security #

Date of Birth

Date Signed

Printed Address

Last date attended

School

Witness

I authorize this medical information to be sent by facsimile, (fax), or email to telephone number _____.

I understand that use of the fax or email to transmit medical information could result in loss of confidentiality of these medical records/information.

I am willing to accept the risk.

Signature of Patient

Witness