Office of Student Health Services
1 Drexel Drive – Box 36
New Orleans, La.70125

Office: (504) 520-7396
Fax: (504) 520-7962

Authorization for Release of Health Information

Patient Information:

Name: _____ D.O. B. _____/_____/_____

ID# or SSN: _____ Phone #: _____

I authorize Xavier University Student Health Services to release a copy of my medical information to _____

(Name of person / facility to which disclosure is to be made)

_____

Address City State Zip code

_____ _____

Telephone# Fax#

Please place check mark next to information to be released:

____Complete Medical Chart ____Immunization Records
____Progress Notes for date(s) of service from _____ to _____
____Lab / X-ray report(s) for date(s) of service from _____ to _____

Other (specify) _____

This authorization is effective on the date signed below and continues until I revoke this authorization in writing or 90 days from the date signed. If I authorize this medical information to be sent by facsimile, I acknowledge and accept the risk that use of the fax to transmit medical information could result in loss of confidentiality of this medical record / information. I understand there is a charge for copying and handling my request. By signing this authorization, I agree to pay these fees at the time this request is made.

Signature: _____ Date: ____/____/____

Copying Fees
Medical Records
$1.00 per page – 1st 25 pages
$0.50 per page – pages 26 – 500
$0.25per page thereafter

Immunization Records
$2.00 a copy (pick up in office)
Faxes: $7.00 (out of state)
$4.00 (in state)
US Mail: $4.00
E-mail: $4.00

To pay by Credit Card please complete the Credit Card Information Form ☞

Credit Card Information Form

Credit Card: __VISA, __Master Card, __American Express, __Discover

Card#_____

Expiration Date: _____ Security Code: _____

Note The security code is located on the back of the card.**
American Express security code is located on the front of the card

Name and Address of Card Holder: **Please Print**

_____

_____

_____