

CONSENT AND AUTHORIZATION TO RELEASE INFORMATION

1,		, Date of E	Birth
	River Oaks Hospital 1525 River Oaks Road West New Orleans, LA 70123-2199 (504) 734-1740	800	
to release and obtain my r	medical records or information cor	ncerning my medical records to	and from:
1		Name of Person/Organization	198020-12
		Street Address	
- 4		City/State/Zip Code	*
	Phone Number	Fax Number	relationship to patient
SPECIFIC EXTENT O			
Dates of Hospitalization Admission Record Consultation Reports Diagnosis Discharge Summary	Physical Physician Orders Progress Notes Psychiatric Evaluation	☐ Alcohol/Drug Usage Info ☐ HIV/AIDS Info ☐ Other (Specify)	9
☐ Educational Evaluations ☐ History		D out of opening	
Listory	L. J SOCIAL PRISTORY		
I understand that I have the	e right to refuse to disclose HIV ter ASE OF INFORMATION:	st results. 🗍 I DO NOT AUTHOR	IZE release of HIV test results.
I understand that I have the REASON FOR RELEA I understand that I may rev specific request to revoke	e right to refuse to disclose HIV tes	except to the extent that action acv Officer. I further understand	has been taken by providing a
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denial, you the patient, possess the right to have the denial reviewed.

FORM A-1 (12/11)