Xavier University of Louisiana
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	**Immunization Records**
Medical Records	$2.00 a copy (In person)
$1.00 per page – 1st 25 pages	$4.00 Faxes (in state)
$0.50 per page – pages 26 – 500	$7.00 Faxes (out of state)
$0.25per page thereafter	$4.00 US Mail / E-mail

Please use the following link to make your payment:
https://commerce.cashnet.com/studenthealthservices