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 to Xavier University

Patient Information:

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

ID# or SSN: _____ **Phone #: _____**

I authorize _____ to release a copy of my medical

information to **Xavier University of Louisiana, Office of Student Health Services, 1 Drexel Drive, Box 36, New Orleans, LA. 70125.**

Method of Delivery:
US Mail - 1 Drexel Drive, Box 36, New Orleans, LA. 70125
Fax – (504)520-7962
Email: healthservices @xula.edu

Please place check mark next to information to be released:

__Immunization Records
__Complete Medical Chart
__Progress Notes for date(s) of service from _____ to _____
__Lab / X-ray report(s) for date(s) of service from _____ to _____
__Alcohol and/or Drug abuse treatment/information
__HIV test results and/or HIV treatment information
__Psychiatric treatment and/or information
__Other: _____

Purpose for Release: ○Medical ○ Insurance ○ Legal ○ Other _____

In authorizing the release of the confidential information identified above, I hereby waive all restrictions or privileges imposed by law and release Xavier University of LA and its affiliates and their staff from any restriction or privilege imposed by law in connection with the disclosure or release of any professional record, observation or communication.

I do understand that the information that is being released may be subject to re-disclosure by the recipient and may no longer be protected. I understand that my treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. This authorization may be revoked in writing at any time, except to the extent that Xavier University of LA, and its affiliates have already taken action in reliance on it.

Letters to revoke this authorization should be addressed to Xavier University of LA, Student Health Services, 1Drexel Dr., Box 36, New Orleans, LA. 70125.

If not previously revoked in writing, this authorization will terminate or expire upon (state the specific date, event, or condition):

This authorization is effective on the date signed below and continues until I revoke this authorization in writing or one year from the date signed**.**

Signature of Patient: _____Date: ____/_____/_____

Signature of Authorized Representative _____Date: ____/_____/_____

Relationship to patient _____