Louisiana Authorization to Release or Obtain Health Information

(Including Paper, Oral, & Electronic Information)

Name	Request Date
Mailing Address	Date of Birth
City/State/Zip	Medicaid # or Social Security #

I authorize:

Name: _____

Mailing Address: _____

City, State, Zip Code: _____

Relationship: _____ Telephone Number:_____

❒ **TO RELEASE Information TO OR ❒ TO OBTAIN Information FROM**

(Place an "X" in the box that indicates if the information is being released OR requested.)

Name: _____

Mailing Address: _____

City, State, Zip Code: _____

Relationship: _____ Telephone Number:_____

The **Purpose of this Authorization** is indicated in the box(es) below. *(Place an "X" in the box(es) that apply.)*

❒ Further Medical Care ❒ Personal ❒ Legal Investigation or Action ❒ Changing Physicians
❒ Research related treatment ❒ Creating health information for disclosure to a third party.
❒ Other: (Specify)_____

I authorize the release of the following protected health information.
(Place an "X"in the box(es) that apply to the information you want released or you want to obtain.)
❒ Entire Record ❒ Medical History, Examination, Reports ❒ Surgical Reports ❒ Treatment or Tests
❒ Prescriptions ❒ Immunizations ❒ Hospital Records including Reports ❒ Laboratory Reports
❒ X-ray Reports ❒ MR/DD Records ❒ Other: _____

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records.
❒ Alcoholism † ❒ Drug Abuse † ❒ Mental Health ❒Vocational Rehabilitation ❒ HIV (AIDS)
❒ Sexually Transmitted Diseases ❒ Genetics ❒ Psychotherapy Notes
❒ Other_____

This authorization shall expire on _____ (date or event) and is needed for the period beginning _____and ending _____.

I understand that if I do not specify an expiration date, this authorization will expire six (6) months from the date on which it was signed. I acknowledge that I have read both pages 1 and 2 of this form.

_____ _____
Signature of Individual or Personal Representative Authorized by Law Date

_____ _____
Signature of Witness *(If signed with an "X" or mark)* Date

For Use When Requesting Records

I am authorized to receive this disclosure. Documentation on the above Personal Representative has been obtained.

_____ _____
Signature and Title of Agency Representative Date

† Provider shall be given a copy of signed document that acknowledges their receipt of Federal Rule 42 CFR § 2.32 - Prohibition on redisclosure.