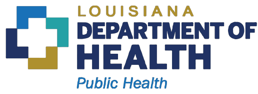

Bureau of Health Informatics

Office of the Secretary
Louisiana Hospital Inpatient Discharge Database (LaHIDD)

HOSPITAL REGISTRATION FOR LaHIDD DATA SUBMITTAL

(To be Completed by Hospital)

Full Name of Hospital: ____

Primary Contact Name:____
Address: ____
Telephone Number: ________________________ Fax Number: ________________________
E-Mail Address: ____

Primary Contact Name: ____
Address: ____
Telephone Number: ____________________ Fax Number: ______________________
E-Mail Address: ____

Method through which your facility will submit LaHIDD data (Check only one):

____ **Directly to LDH through secure, Internet-based server**
____ **Designate an intermediary**

If designating an intermediary, please complete the following**:**

Name of Intermediary: ____
Contact Name: ____
Address: ____
Telephone Number: ____________________ Fax Number: ______________________

E-Mail Address: ____

____ ________________
Signature of Hospital Representative Date

For LAHIDD Use Only
Received and Acknowledged:

____ ________________________
Starr Moore-Reisz, LAHIDD/Spatial Intelligence Program Manager *Date*

Send the completed form to:

Starr Moore-Reisz, M.A., Bureau of Health Informatics
Louisiana Department of Health, Office of Public Health
628 N. 4th Street 3rd Floor, Bin #4
Baton Rouge, Louisiana 70802

OR

Email: **Starr.Moore2@la.gov**