Louisiana Department of Health and Hospitals

Authorization to Release Health Information

(including paper, oral and electronic information)

Name:	Social Security #:
Mailing Address:	Date of Birth:
City/State/Zip code:	Telephone #:

I authorize any provider that has treated me or is presently treating me to release requested Protected Health Information (PHI) to:

Agency Name:
Mailing Address:
City/ State/ Zip code :

As the purpose of this authorization is to establish Medicaid eligibility, I authorize the release of all of the following protected health information:
Medical History, Examination, Reports, Surgical Reports, Treatment or Tests, Prescriptions, Immunizations, Hospital Records including Reports, Laboratory Reports, X-ray Reports, DD Records, Discharge summaries

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

I do not authorize the release of the following types of my health information: (If none, leave blank)

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Please provide medical records for the time period of ___________________ through ______________________.

This authorization to release medical information shall expire on: _________________________.
(date)

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. I authorize a copy (including electronic or faxed copy) of this form for the disclosure of the information described above.

____ ______________________

Signature of individual or personal representative authorized by law Date

FOR OFFICE USE ONLY:

Agency Representative:		Date:
Telephone:	Fax:	Email:

HIPAA 202L
Issued 12/11

Important Information about Authorization

Medicaid may need your authorization to obtain your health information to determine your eligibility.

You do not have to sign this form. If you agree to sign this authorization to release information, you will be given a signed copy of the form.

A separate signed authorization form is required for the use and disclosure of Psychotherapy notes as defined by the HIPAA Privacy Rule.

When required by law or policy, Medicaid may only obtain your health information if the required written authorization includes all the required elements of a valid authorization.

An authorization is voluntary. You will not be required to sign an authorization as a condition of receiving treatment services or payment for health care services. If your authorization is required by law or policy, Medicaid will use and disclose your health information as you have authorized on the signed authorization form.

You may cancel an authorization in writing at any time but the cancellation will not affect any uses or disclosures already made before an authorization was cancelled.

Information disclosed by this authorization may be re-disclosed by Medicaid in accordance with applicable law.