



**Authorization to Release or Obtain Health Information
(including paper, oral and 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 LDH 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.

Important Information about Authorization

We may need your authorization to use, disclose or obtain your health information for some of our services.

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

A separate signed authorization form is required for the use and disclosure of health information for:

- Psychotherapy notes
- Employment-related determinations by an employer
- Research purposes unrelated to your treatment
- Substance Use (Alcohol and Drug Use)

When required by law or policy, LDH may only obtain, use and disclose 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, LDH will use and disclose your health information as you have authorized on the signed authorization form.

You may be required to sign an authorization before receiving research-related treatment.

You may be required to sign an authorization form for the purpose of creating protected health information for disclosure to a third party. *Example:* In a juvenile court proceeding where a parent is required to obtain a psychological evaluation on their minor child by LDH, the parent may be required to sign an authorization to release the evaluation report (but not the psychotherapy notes) to LDH.

You may cancel an authorization in writing at any time. LDH can not take back any uses or disclosures already made before an authorization was cancelled.

Information used or disclosed by this authorization may be re-disclosed by the recipient and will no longer be protected by LDH privacy policies.

YOUR RIGHT TO FILE A PRIVACY COMPLAINT

You may contact the privacy office listed below if you want to file a complaint or to report a problem about how LDH has used or disclosed information about you. Your benefits will not be affected by any complaints you make. LDH cannot punish or retaliate against you for filing a complaint, cooperating in any investigation, or refusing to agree to something that you believe to be unlawful.

Your Privacy office contact is:

State of Louisiana - Louisiana Department of Health
Office of Secretary - Privacy Office
Post Office Box 629
Baton Rouge LA 70821-0629
Email: privacy-LDH@la.gov