

Louisiana Authorization (HIPAA) 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.