

**Consent for the Release of Confidential Information
Louisiana Services Network Data Consortium (All Providers)**

**Authorization to Release or Obtain Information
(including paper, oral and electronic information)**

To better address some needs and coordinate services, a request may be made to share sensitive personal information that is protected from public disclosure. Confidential information can include, but is not restricted to, health-related issues (physical and mental impairments, illnesses and conditions, addictions and treatments); domestic violence issues; or issues related to unaccompanied youth.

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

I authorize:

Name: _____

Mailing Address: _____

City, State, Zip Code _____ Phone: _____

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.)

- Eligibility Determination
 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.)

- | | | |
|---|---|---|
| <input type="checkbox"/> Entire Record | <input type="checkbox"/> Medical History, Examination, Reports | <input type="checkbox"/> Surgical Reports |
| <input type="checkbox"/> Treatment of Tests | <input type="checkbox"/> Prescriptions <input type="checkbox"/> Immunizations | <input type="checkbox"/> Laboratory Reports |
| <input type="checkbox"/> Hospital Records including Reports | <input type="checkbox"/> X-ray Reports | <input type="checkbox"/> MR/DD Reports |
| <input type="checkbox"/> Other: _____ | | |

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records:

- | | | | | |
|--|-------------------------------------|--|--|-------------------------------------|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Mental Health | <input type="checkbox"/> Vocational Rehabilitation | <input type="checkbox"/> HIV (AIDS) |
| <input type="checkbox"/> Sexually Transmitted Diseases | <input type="checkbox"/> Genetics | <input type="checkbox"/> Psychotherapy Notes | <input type="checkbox"/> Foster Care Records | |
| <input type="checkbox"/> 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 twelve (12) months from the date signed.
- I acknowledge that I have fully read this form.
- The regulations are the Federal Law of Confidentiality for Alcohol and Drug Abuse Patients, (42 CFR, Part 2) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CRF, Parts 160 & 164.
- I understand that there may have been information shared and services provided based on this consent when it was in effect. Ending this consent cannot change that.

Signature of Individual or Personal Representative Authorized by Law Date

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

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. If you do not agree to release of information required to determine your eligibility for enrollment in our program or to determine your entitlement to benefits we may not be able to make the required eligibility determinations.