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.*)

□ Entire Record □ Medical History, Examination, Reports □ Surgical Reports
□ Treatment of Tests □ Prescriptions □ Immunizations □ Laboratory Reports
□ Hospital Records including Reports □ X-ray Reports □ MR/DD Reports
□ 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 □ Foster Care Records
□ 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.

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