

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 ID # or Social Security

I authorize:

Name: O'Brien House

Mailing Address: 1231 Laurel Street

City, State, Zip Code: Baton Rouge, LA 70802

Relationship: Treatment Provider Telephone Number: (225) 344-6345

TO RELEASE Information TO **AND** **TO OBTAIN Information**
FROM

(Place an X" in the box that indicates if the information is being released OR requested.)

Name: Molly Cline / Dusty Guidry - DA's Office

Mailing Address: 233 St. Ferdinand Street Room#210

City, State, Zip Code: Baton Rouge, LA 70802

Relationship: Legal

Telephone Number: (225)389-3428

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 sides of this form.

X _____
Signature of Individual or Personal Representative Authorized by Law

X _____
Date

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

Date

For Agency 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

HIPAA

