Louisiana Department of Children and Family Services
Authorization to Release Protected Health Information

(includes paper, oral, and electronic information)

1. Client Name:	Medicaid # or Social Security #:
Mailing Address:	Date of Birth:
City/State/Zip Code:	Request Date:

I authorize:

2. Name:

Mailing Address:	City/State/Zip Code:
Relationship:	Telephone Number: ( )

To release information to:

3. Name:

Mailing Address:	City/State/Zip Code:
Relationship:	Telephone Number: ( )

4. The purpose of this authorization is indicated in the box(es) below: *Check (✓) the boxes that apply.*

☐ Investigation/Assessment/Case Planning ☐ Further Medical Care ☐ Changing Physicians

☐ Creating Health Information for Disclosure to a Third Party ☐ Foster/Adoptive Parent Assessment

☐ Determining Eligibility/Program Exemptions ☐ Other:

I authorize the release of the following protected health information: *Check (✓) the boxes that apply to the information you want released.*

☐ 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: *Check (✓) the boxes that apply.*

☐ Alcoholism ☐ Drug Abuse ☐ Mental Health ☐ HIV (AIDS)

☐ Sexually Transmitted Diseases ☐ Genetics ☐ Psychotherapy Notes ☐ Other:

Client Name:	Medicaid # or Social Security #:

5. 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

_____
Description of Personal Representative's Authority to Act (relationship, etc.)

_____ _____
Signature of Witness *(required if signed with an "X" or mark)* Date

6. For Agency Use When Requesting Records

I am authorized to receive this disclosure. Documentation of the Personal Representative (if designated in Item 5) has been obtained.

_____ _____
Signature and Title of Agency Representative Date

Important Information about Authorization

The Department of Children and Family Services (DCFS), as well as the covered entity, may need your authorization to use, disclose, or obtain your health information for some of our services.

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

When required by law or policy, we 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 by a covered entity. If your authorization is required by law or policy, we will use and disclose your health information as you have authorized on this signed authorization form. Certain DCFS programs may require that the Department obtain and review your health information before making an eligibility determination or providing services.

You may be required to sign an authorization before receiving research-related treatment. You may also be required to sign an authorization form for the purpose of creating protected health information for disclosure to a third party.

If you agree to sign this authorization to release or obtain information, you will be given a signed copy of the form.

You may cancel an authorization in writing at any time. Any uses or disclosures already made before an authorization was cancelled cannot be taken back. Information used or disclosed by this authorization may be re-disclosed by the recipient and will no longer be protected by our privacy policies.