



**STATE OF LOUISIANA - OFFICE OF GROUP BENEFITS
RELEASE OF DEPENDENT CHILD
PROTECTED HEALTH INFORMATION (PHI)**



Authorization Pursuant to 45 CFR 164.524(c)(4)

| | | | |
|--|------|---------------|----------|
| DEPENDENT CHILD NAME | | /NICKNAME | |
| DEPENDENT CHILD SOCIAL SECURITY NUMBER | | DATE OF BIRTH | |
| NAME OF HEALTH CARE PROVIDER AUTHORIZED TO MAKE THE REQUESTED DISCLOSURE TO OGB | | | |
| HEALTH CARE PROVIDER ADDRESS | CITY | STATE | ZIP CODE |
| <p>I authorize you to disclose all protected health information to the Office of Group Benefits (OGB) for the purpose of determining <u>my eligibility</u> or <u>my dependent child's eligibility</u> (circle one) for continuing health care benefits coverage with OGB. I expressly authorize you to disclose full and complete medical information, including without limitation, any health care records, treatment (including those related to mental illness and/or AIDS/ARC/HIV, but excluding any psychotherapy notes in your possession), and/or medical equipment or supplies provided to me/my dependent child.</p> | | | INITIALS |
| <p>I understand and acknowledge that the covered entity to whom this authorization is directed may not condition my treatment, payment, enrollment or eligibility on whether or not I sign this authorization; however, pursuant to 45 CFR 154:508(b)(4)(ii), OGB may condition eligibility and enrollment determinations on whether I sign this authorization.</p> | | | INITIALS |
| <p>I authorize you to release information to the OGB and/or any independent claims administrators, consulting health care professionals, and/or utilization review organizations with whom OGB contracts.</p> | | | INITIALS |
| <p>I understand and acknowledge that I have a right to revoke this authorization at anytime by notifying you and OGB in writing; however, I understand that any actions already taken in reliance on this authorization cannot be reversed and my revocation will not affect those actions, including actions related to OGB's right to contest a claim.</p> | | | INITIALS |
| <p>I acknowledge the potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.</p> | | | INITIALS |
| <p>I agree that a photographic copy of this authorization is as valid as the original.</p> | | | INITIALS |
| <p>I understand that I may see and copy information described on this form if I ask it, and that I am entitled to a copy of this form after I sign it.</p> | | | INITIALS |
| <p>This authorization is valid for so long as I seek eligibility and/or enrollment determinations for continued health care benefits with OGB on my behalf and/or on behalf of my dependent child.</p> | | | INITIALS |



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Signature of Plan Member (Or His/Her Representative)

Date

If this form is signed by a personal representative, complete the following:

Printed Name of Plan Member's Representative

Relationship to Plan Member (Including authority to act as personal representative)