



STATE OF LOUISIANA - OFFICE OF GROUP BENEFITS REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION



NOTICE

In accordance with 45 CFR 164.524(c)(4), OGB will impose a reasonable, cost-based fee for copies requested.

PLAN MEMBER NAME	DATE OF BIRTH(MM/DD/YYYY)	MEMBER ID NUMBER	
ADDRESS	CITY	STATE	ZIP CODE
TELEPHONE (PRIMARY)	TELEPHONE (ALTERNATE)		

I hereby request access to my (or my dependent, minor child's) protected health information for the purpose of inspection and/or obtaining copies. This authorization will remain in effect until revoked or as otherwise provided herein.

PERSON OR PERSONS TO WHOM OGB IS AUTHORIZED TO DISCLOSE:

NAME (FIRST, M.I., LAST)	Date of Birth (DD/MM/YYYY)
NAME (FIRST, M.I., LAST)	Date of Birth (DD/MM/YYYY)
NAME (FIRST, M.I., LAST)	Date of Birth (DD/MM/YYYY)
NAME (FIRST, M.I., LAST)	Date of Birth (DD/MM/YYYY)

SPECIFIC DOCUMENTS REQUESTED

- All
- Claims
- Remittance Records
- Correspondence
- Other (Please specify): _____

Requested record dates are, or date range is: _____

SPECIFIC PURPOSE OF DISCLOSURE

- At the request of the health plan member who is the subject of the information
- Other (specify): _____

This authorization will expire: _____



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REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION
(Continued)**



CERTIFICATION

I understand that this authorization is voluntary.

Initials: _____

I understand that my health care and the payment for my health care will not be affected if I do not sign this form, and that OGB will not condition payment, enrollment, or eligibility on whether I sign this authorization.

Initials: _____

This authorization is made at the request of the individual who is the subject of the protected health information. I understand and acknowledge that I have a right to revoke this authorization at any time 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.

Initials: _____

I acknowledge the potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and no longer protected under federal privacy regulations.

Initials: _____

I agree that a photographic copy of this authorization is as valid as the original.

Initials: _____

I understand that I am entitled to a copy of this form after I sign it.

Initials: _____

I understand that I may revoke this authorization at any time by notifying the Office of Group Benefits in writing, but that if I do so the revocation will not have any effect on actions the OGB took before the revocation was received.

Initials: _____

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)