STATE OF LOUISIANA, OFFICE OF GROUP BENEFITS
AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the Office of Group Benefits (OGB) to use or disclose my health information as described below.

Health plan member/dependent name: _____

Member ID number: _____

Persons/organizations to receive the information:

Specific description of the information (including date(s)) covered by this authorization:

Purpose of the use or disclosure (check one):

___ At the request of the health plan member/dependent who is the subject of the information

___ At the request of the OGB, for the following reason:

_____

Date or event when this authorization will expire:

The health plan member/dependent or his/her representative must read and initial the following statements:

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 the OGB will not condition payment, enrollment, or eligibility on whether I sign this authorization.
Initials: _____

I understand that if any organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
Initials: _____

I understand that I may see and copy the information described on this form if I ask for it, and 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. (This subject is also discussed in the OGB's Notice of Privacy Practices, a copy of which is available to me on request.)
Initials: _____

_____ _____
Signature of Health Plan Member/Dependent or Representative Date

(Form must be completed before signing.)

Printed name of health plan member/dependent's representative:

_____

Relationship to health plan member/dependent:

_____