STATE OF LOUISIANA
DIVISION OF ADMINISTRATION
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:

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

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Purpose of the use or disclosure (check one):

☐ At the request of the health plan member who is the subject of the information

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

____

Date or event when this authorization will expire:

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Signature of Health Plan Member/Dependent or Representative Date