



STATE OF LOUISIANA - OFFICE OF GROUP BENEFITS

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION



PLAN MEMBER NAME	PLAN MEMBER NUMBER	DATE OF BIRTH	
ADDRESS	CITY	STATE	ZIP CODE
EMAIL ADDRESS	TELEPHONE	ALTERNATE TELEPHONE	

I hereby authorize the Office of Group Benefits (OGB) to disclose the information described below, verbally or in writing, to the person or entity identified below. This authorization will remain in effect until revoked or as otherwise provided herein.

Plan Participant(s) for whom OGB is authorized to disclose:

NAME (FIRST, M.I., LAST)	DATE OF BIRTH
NAME (FIRST, M.I., LAST)	DATE OF BIRTH
NAME (FIRST, M.I., LAST)	DATE OF BIRTH
NAME (FIRST, M.I., LAST)	DATE OF BIRTH

Individual/Entity Authorized to Receive and Use Information:

NAME	RELATION TO MEMBER		
ADDRESS	CITY	STATE	ZIP CODE

Specific Description of Information to be Disclosed (If nothing is provided here, all will be assumed):

Specific Purpose of Disclosure:

- ☐ At the request of the Health Plan member who is the subject of the information.
- ☐ At the request of OGB , for the following reason:
- ☐ Other (Specify):

This authorization will expire:	DATE
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HEALTH INFORMATION



(CONTINUED)

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
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 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 OGB in writing, but that if I do so, the revocation will not have any effect on actions 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, please complete the following:	
PRINTED NAME OF PLAN MEMBER'S REPRESENTATIVE	
RELATIONSHIP TO PLAN MEMBER (INCLUDING AUTHORITY TO ACT AS A PERSONAL REPRESENTATIVE)	