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: _____

STATE OF LOUISIANA - OFFICE OF GROUP BENEFITS
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)