STATE OF LOUISIANA
DIVISION OF ADMINISTRATION
OFFICE OF GROUP BENEFITS

Request for Access to Protected Health Information(PHI)

Plan Member Name:____

Plan Member Number:__________________________ **Date of Birth:** ____/____/____

Address:____

City:____________________________ **State:**____________ **Zip Code:**____________

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.

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

Name:______________________________________ **Date of Birth:** ____/____/____
Name:______________________________________ **Date of Birth:** ____/____/____
Name:______________________________________ **Date of Birth:** ____/____/____
Name:______________________________________ **Date of Birth:** ____/____/____

Specific Documents Requested:

☐All
☐Claims
☐Remittance Records
☐Correspondence
☐Other (Specify):

____

The 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 (PHI)
(*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 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 OGB took before the revocation was received.

Initials:__________

____ _________ /_________ / ____________

Signature of Plan Member **Date**
(Or His/Her Representative)

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.)