STATE OF LOUISIANA
DIVISION OF ADMINISTRATION
OFFICE OF GROUP BENEFITS

Medical Release Authorization Pursuant to 45 CFR 164.508

Name of health care provider authorized to make the requested disclosure:

_____

_____

_____

Patient/Dependent Child's Name: _____ AKA: _____
Date of Birth: _____ SSN: _____

I authorize you to disclose all protected medical information for the purpose of determining my eligibility for continuing health care benefits coverage with the Office of Group Benefits ("OGB"). I expressly request that you disclose my full and complete medical information, including without limitation, any health care records, treatment (including that related to mental illness and/or AIDS/ARC/HIV, but excluding any psychotherapy notes in your possession), and/or medical equipment or supplies provided to me.

I authorize you to release this information to the Office of Group Benefits and/or any independent claims administrators, consulting health care professionals, and utilization review organizations with whom OGB contracts.

This authorization is made at the request of the individual who is the subject of the protected 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.

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 45 CFR 164.508.

I understand and acknowledge that the covered entity to whom this authorization is directed may not condition my treatment, payment, enrollment or eligibility on whether or not I sign this authorization; however, pursuant to 45 CFR 154.508(b)(4)(ii), OGB may condition eligibility and enrollment determinations on whether I sign this authorization.

I agree that a photographic copy of this authorization is as valid as the original.

This authorization is valid for so long as I seek eligibility and/or enrollment determinations for continued health care benefits with OGB.

Signature and date of patient/dependent child or representative:_____

Printed name of signing party (dependent child or representative):_____

Date and Signing party's relationship to dependent child:_____