STATE OF LOUISIANA
DIVISION OF ADMINISTRATION
OFFICE OF GROUP BENEFITS

Authorization for Disclosure of Protected Health Information (PHI)

Plan Member Name: _____

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

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

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

_____

_____

_____

_____

_____

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: ____/____/____

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Authorization for Disclosure of 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 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 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.)