STATE OF LOUISIANA
DIVISION OF ADMINISTRATION
OFFICE OF GROUP BENEFITS

Authorization for Disclosure of Protected Health Information (PHI)

Customer Service Department
(Revised 02.24.14)

Member Name: _____

Patient Record Number: _____ **Date of Birth:** _____ /____ _/ _____

Address: _____

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

For the purpose of assisting with matters related to the payment for health care services, I hereby authorize the Office of Group Benefits (OGB) to disclose claim status, claims payment, and/or enrollment information, verbally or in writing, regarding me and my minor dependents to the individual identified below. This authorization will remain in effect until revoked or until the termination date indicated below.

Termination Date: ____ /____ /_____

Individual Authorized to Receive Information:

Name: _____

Relation to Member: _____

Address: _____

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

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 understand that when an individual or organization authorized to receive information is not a health plan or health care provider, that information may no longer be protected by federal privacy regulations. 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 the OGB took before the revocation was received. (This subject is also discussed in the OGB's Notice of Privacy Practices, a copy of which is available to me on request.)

Initials: _____

_____ _____ /_____ / _____

Signature of Plan Member **Date**