AUTHORIZATION TO RELEASE OR OBTAIN HEALTH INFORMATION

Name:	Request Date:
Mailing Address:	Date of Birth:
City/State/Zip:	Other Info if Needed:

I Authorize:

Name: _____

Mailing Address: _____

City/State/Zip: _____

Relationship: _____ Phone: _____ Fax: _____

☐ TO RELEASE INFORMATION TO OR ☑ TO OBTAIN INFORMATION FROM

(Place an X in appropriate boxes)

Name: _____

Mailing Address: _____

City/State/Zip: _____

Relationship: _____ Phone: _____ Fax: _____

The Purpose of this Authorization is indicated in the boxes below (Place an X in the boxes that apply):

☐ Personal ☐ Obtain Medication ☐ Medical Care ☐ Legal X Admission to facility ☐ Disclosure to third party

☐ Transfer Case ☐ Other (Specify): _____

Additional Explanation: _____

In Compliance with State and Federal Laws Requiring Special Permission to Release Otherwise Privileged Information, I Authorize the Release of the Following Protected Health Information:

☐ Admit Date ☐ D/C Date ☐ ASI ☐ Progress Notes ☐ Treatment History ☐ HIV/AIDS Status

☐ Acknowledge Presence at Facility ☐ Completion of Program ☐ Compliance with Program

☐ Medical History/Exams/Reports ☐ Hospital Records/Reports/Tests ☐ Mental Health ☐ Lab Reports

☐ MR/DD Records ☐ Prescriptions/Medications ☐ Other (Specify): _____

Transmission of this information is to be accomplished by the following means: (check all that apply)

☐ Verbal ☐ Letter ☐ Fax ☐ Other: _____

This authorization shall expire on _____. I understand that if I do not specify an expiration date, this authorization will expire six (6) months from the date on which it was signed.

Signature: _____ Date: _____

Witness: _____ Date: _____

It is understood that the release of information is for professional purposes only and may not be provided to any other agency, organization, or individual without the client's specific written release of such. Information is disclosed from records protected by Federal Confidentiality Rules (42 CFR Part 2) and prohibit making any further disclosure of this information unless the further disclosure of it is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by (42 CFR Part 2). A general authorization for the release of medical or other information is not sufficient for the purpose. Federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient. It is to be further understood by the person signing this form that the FAX system and other forms of transmission may not be confidential and, therefore, this agency is released from any liability for any information becoming available to unauthorized persons as the ability to secure these systems of transmission is beyond the control of this agency.

Important Information About Authorization

You do not have to sign this form. If you agree to sign this authorization to release or obtain information, you will be given a signed copy of the form. If you do not agree to release of information required to determine your eligibility for enrollment in our health plan or to determine your entitlement to benefits we may not be able to make the required eligibility determinations.

A separate signed authorization form is required for the use and disclosure of health information for:

- ✓ Psychotherapy notes
- ✓ Employment-related determinations by an employer
- ✓ Research purposes unrelated to your treatment

When required by law or policy, this agency may only obtain, use and disclose your health information if the required written authorization includes all the required elements of a valid authorization.

An authorization is voluntary. You will not be required to sign an authorization as a condition of receiving treatment services or payment for health care services. If your authorization is required by law or policy, this agency will use and disclose your health information as you have authorized on the signed authorization form.

You may be required to sign an authorization before receiving research-related treatment.

You may be required to sign an authorization form for the purpose of creating protected health information for disclosure to a third party. *Example:* In a juvenile court proceeding where a parent is required to obtain a psychological evaluation on their minor by this agency, the parent may be required to sign an authorization to release the evaluation report (but not the psychotherapy notes) to this agency.

You may cancel an authorization in writing at any time. This agency cannot take back any uses or disclosures already made before an authorization was cancelled.

Information used or disclosed by this authorization may be re-disclosed by the recipient and will no longer be protected by this agency's privacy policies.

Your right to file a privacy complaint

You may contact the Privacy Office listed below if you want to file a complaint or to report a problem about how this agency has used or disclosed information about you. Your benefits will not be affected by any complaints you make. This agency cannot punish or retaliate against you for filing a complaint, cooperating in any investigation, or refusing to agree to something that you believe to be unlawful. Your Privacy Office contact is:

Iberville Parish Substance Abuse Center
Director: G. Bert Allain
24705 Plaza Drive, Suite B
Plaquemine, LA 70764

Phone: 225-687-5889
Fax: 225-687-5893