**Authorization to Release or Obtain Health Information (including paper, oral and electronic information), Page 1 of 2**

Name: _____ Request Date: _____
Mailing Address: _____ Date of Birth: _____
City/State/Zip: _____ Medicaid # or Social Security #: _____

**I authorize:**
Name: Capital Area Human Services District (CAHSD) Medical Records
Mailing Address: P.O. Box 66558; Baton Rouge, LA 70896-6558
Phone: 225-925-1863; 225-964-5281; 225-964-5285 Fax: 888-971-4031 Email: cahsmedicalrecords@la.gov
Relationship: Behavioral Health Service Provider

**☒TO RELEASE Information TO or ☒TO OBTAIN Information FROM**

Name: _____
Mailing Address, City, State, Zip Code: _____
Phone: _____Fax: _____Email: _____
Relationship: _____

The **Purpose of this Authorization** is indicated in the box(es) below. *(Place an "X" in the box(es) that apply.)*
❒Further Medical Care ❒Personal ❒Legal Investigation or Action ❒Changing Physicians ❒Research related treatment
❒Creating health information for disclosure to a third party ❒Other (Specify)_____

**I authorize the release of the following protected health information.**
*(Place an "X" in the box(es) that apply to the information you want released or you want to obtain.)*
❒Entire Record ❒Medical History, Examination, Reports ❒Surgical Reports ❒Treatment or Tests ❒Prescriptions
❒Immunizations ❒Hospital Records including Reports ❒Laboratory Reports ❒X-ray Reports ❒MR/DD Records
❒Other (Specify)_____

**In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records.** *(Place an "X" in the box(es) that apply.)*
❒Alcoholism† ❒Drug Abuse† ❒Mental Health ❒Vocational Rehabilitation ❒HIV (AIDS)
❒Sexually Transmitted Diseases ❒Genetics ❒Psychotherapy Notes ❒Other_____

**This authorization shall expire on_____ (date or event) and is needed for the period beginning (e.g., admission date) _____and ending (e.g., discharge date) _____.**

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. I acknowledge that I have read both pages of this authorization form.

_____ _____
Signature of Individual or Personal Representative Authorized by Law Date

_____ _____
Signature of Witness *(If signed with an "X" or mark)* Date

**For CAHSD Use When Requesting Records**
*I am authorized to receive this disclosure. Documentation on the above Personal Representative has been obtained.*

_____ _____
Signature and Title of Agency Representative Date

**† Provider shall adhere to Federal Rule 42 CFR § 2.32 - Prohibition on redisclosure.**

We may need your authorization to use, disclose or obtain your health information for some of our services.

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.

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; and Substance Use (Alcohol and Drug Use).

When required by law or policy, CAHSD 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, CAHSD 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 child by CAHSD, the parent may be required to sign an authorization to release the evaluation report (but not the psychotherapy notes) to CAHSD.

You may cancel an authorization in writing at any time. CAHSD 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 CAHSD 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 CAHSD has used or disclosed information about you. Your benefits will not be affected by any complaints you make. CAHSD 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:

Privacy Officer
Capital Area Human Services District
P.O. Box 66558; Baton Rouge, LA 70896-6558
Phone 225-922-2700