Authorization to Release or Obtain Health Information

(including paper, oral and electronic information)

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

I authorize:

Name: O'Brien House

Mailing Address: 1231 Laurel Street

City, State, Zip Code: Baton Rouge, LA 70802

Relationship: Treatment Provider Telephone Number: (225) 344-6345

☒ **TO RELEASE Information TO** **AND** **x❑ TO OBTAIN Information FROM**

(Place an X" in the box that indicates if the information is being released OR requested.)

Name: Molly Cline / Dusty Guidry - DA's Office

Mailing Address: 233 St. Ferdinand Street Room#210

City, State, Zip Code: Baton Rouge, LA 70802

Relationship:Legal Telephone Number: (225)389-3428

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 X❑ 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.)

X 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: _____

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records.

X Alcoholism X 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_____ and ending_____.
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 sides of this form.

X_____ X_____

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

_____ _____

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

For Agency 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