Permission to Share My Information

AUTHORIZATION TO USE OR DISCLOSE SENSITIVE HEALTH INFORMATION

As described in your Privacy Notice, Louisiana Healthcare Connections is required by law to obtain your authorization for any use or disclosure of your health records for purposes other than your treatment, the payment for health care services provided to you and our health care operations. In the Privacy Notice, you receive information about how we can use or disclose your health records. You have a right to review and receive a copy of the Privacy Notice before signing this Authorization.

Member Name: _____ **Date of Birth:** _____

Member ID: _____

I, _____, authorize the use and disclosure of my health information as described below:

1. **Check the box(es) for the type(s) of information that applies to this authorization and then state how much and what information is to be disclosed in the space provided.**

   ☐ AIDS/HIV and other communicable disease (e.g., venereal disease)

   ☐ Mental health information (including behavioral health and psychiatric care)

   ☐ Alcohol and/or drug abuse treatment

   ☐ Genetic testing information

   ☐ Other – please provide more information below.

   _____

   Release records from _____ **to** _____

2. **I authorize the following person(s), entity or program to receive this health information:**

   Name: _____

   Title: _____

   Address: _____

   City/State/Zip: _____

   Phone: _____

3. **We are requesting this authorization in order to use or disclose your health information for the following purpose(s):**

   _____

   _____

   ☐ At the request of the individual

4. **This authorization expires:** _____

(Specify date, event, or condition upon which the consent will expire if not revoked before)
If no expiration date is specified, the authorization will expire six (6) months from the date on which it is signed.

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You may request to inspect or copy the information that Louisiana Healthcare Connections intends to disclose. You may refuse to sign this Authorization. Louisiana Healthcare Connections will not condition treatment, payment, enrollment, or eligibility for benefits on your providing or refusing to provide this Authorization. Once release of this health information is made to the above-named person or persons, your health information may be subject to redisclosure by that person or persons. If you have authorized the disclosure of health information to someone who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected.

You may revoke this authorization at any time except to the extent that the specified person, persons, class of person or program which is to make the disclosure has already acted in reliance on it. Your revocation must be in writing, signed by you or on your behalf, and delivered to the address at the end of this form. You may deliver your revocation by any means you choose (e.g., personally or by mail), but it will be effective only when we actually receive it. Your revocation will not be effective to the extent that we or others have acted in reliance upon this Authorization.

If you are requesting information for yourself or for a third party, Louisiana Healthcare Connections may assess appropriate and reasonable fees for the copying of such information. Such fees will comply with all state and federal laws.

AUTHORIZATION

I, _____, have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to Louisiana Healthcare Connections. I understand that, by signing this form, I am confirming my authorization that Louisiana Healthcare Connections may use and/or disclose to the persons and/or organizations named in this form the health information described in this form.

_____ _____

Signature of Member or Legal Representative Date

_____

Print Name

If signing on behalf of a member, please describe your authority and provide related documentation:

_____

_____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

FOR HEALTH PLAN USE ONLY

Name: _____ Title: _____

Signature:

PLEASE MAIL YOUR COMPLETED FORM TO:

Louisiana Healthcare Connections, ATTN: Privacy Officer
P.O. Box 84180, Baton Rouge, LA 70884
Or email to: LHCC_CompliancePrivacy@LouisianaHealthConnect.com