LOUISIANA DEPARTMENT OF HEALTH

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 # or Social Security #

I authorize:

Name: Louisiana Department of Health - Medicaid

Mailing Address: 628 North Fourth Street

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

Relationship: Medicaid Provider Telephone Number: (225) 342-9500

☒ **TO RELEASE Information TO** **OR** ☐ **TO OBTAIN Information FROM**

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

Name: RECORDS DEPOSITION SERVICE, INC.

Mailing Address: 120 W MADISON ST., SUITE 300

City, State, Zip Code: CHICAGO, IL, 60602

Relationship: Telephone Number:

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) PRE TRIAL DISCOVERY

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:

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records.
☐ 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** _____ **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 pages 1 and 2 of this form.

Signature of Individual or Personal Representative Authorized by Law — Date

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

For LDH 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 be given a copy of signed document that acknowledges their receipt of Federal Rule 42 CFR § 2.32 - Prohibition on redisclosure.