STATE OF LOUISIANA CHILD OMBUDSMAN

Authorization to Release or Obtain Health Information

(including paper, oral and electronic information)

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

I _____am the personal representative authorized by law of the above-named minor, and I authorize any provider who has treated or is presently treating the above-named minor to release the Protected Health Information (PHI) indicated below to:

State of Louisiana Child Ombudsman
Post Office Box 94397
Baton Rouge, Louisiana 70804-9397
PH: (833) 543-7452 (833-Kids4La) – Email: Kids4La@lla.la.gov

The **Purpose of this Authorization** is to assist the State of Louisiana Child Ombudsman in the legal duties as set forth in La. R.S. 24:525 and 40:2019.

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 ❒ Assessment/Evaluation Reports ❒ 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 Parent or Personal Representative Authorized by Law Date

•Provider shall be given a copy of signed document that acknowledges their receipt of Federal Rule 42 CFR § 2.32 – Prohibition on redisclosure.

HIPAA 10/2023

Important Information about Authorization

We may need your authorization to use, disclose or obtain the minor's health information.

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.

As indicated in the form, a separate authorization is required for the use and disclosure of health information for:

- Psychotherapy notes
- Substance Use (Alcohol and Drug Use)

When required by law or policy, we 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. If your authorization is required by law or policy, we will use and disclose the minor's health information as you have authorized on the signed authorization form.

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