22nd JDC Assistive Outpatient Treatment Court
Authorization to Release Protected Health Information

(includes paper, oral, and electronic information)

1. Patient's Name:	Medicaid # or Social Security #:
Mailing Address:	Date of Birth:
City/State/Zip Code:	Request Date:

I authorize:

2. Name:

Mailing Address:	City/State/Zip Code:
Relationship:	Telephone Number: ( )

To release information to:

3. Name: 22nd JDC AOT Program

Mailing Address: 701 N. Columbia Street	City/State/Zip Code: Covington LA 70433
Relationship: Case manager	Telephone Number: (985) 809-5394

4. The purpose of this authorization is indicated in the box(es) below: *Check (✓) the boxes that apply.*

☐ Program Assessment/Case Planning ☐ Further Medical Care ☐ Changing Physicians

☐ Creating Health Information for Disclosure to a Third Party ☐ Psychiatric/Psychological Assessment

☐ Determining Eligibility/Program Exemptions ☐ Other: by:

_____

I authorize the release of the following protected health information: *Check (✓) the boxes that apply to the information you want released.*

☐ 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: *Check (✓) the boxes that apply.*

☐ Alcoholism ☐ Drug Abuse ☐ Mental Health ☐ HIV (AIDS)

☐ Sexually Transmitted Diseases ☐ Genetics ☐ Psychotherapy Notes ☐ Other:

Patient Name:	Medicaid # or Social Security #:

5. 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

_____

Description of Personal Representative's Authority to Act (relationship, etc.)

_____ _____

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

6. For Agency Use When Requesting Records

I am authorized to receive this disclosure. Documentation of the Personal Representative (if designated in Item 5) has been obtained.

_____ _____

Signature and Title of Agency Representative Date

Important Information about Authorization

The 22nd Judicial District Court, Assistive Outpatient Treatment Court, may need your authorization to use, disclose, or obtain your health information for some of our services.

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. You will not be required to sign an authorization as a condition of receiving treatment services or payment for health care services by a covered entity. If your authorization is required by law or policy, we will use and disclose your health information as you have authorized on this signed authorization form. Certain programs may require that the court obtain and review your health information before making an eligibility determination or providing services.

You may be required to sign an authorization before receiving research-related treatment. You may also be required to sign an authorization form for the purpose of creating protected health information for disclosure to a third party.

If you agree to sign this authorization to release or obtain information, you will be given a signed copy of the form.

You may cancel an authorization in writing at any time. Any uses or disclosures already made before an authorization was canceled cannot be taken back. Information used or disclosed by this authorization may be re-disclosed by the recipient and will no longer be protected by our privacy policies.