Louisiana Department of Health and Hospitals

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: 22nd Judicial District Drug Court Co-occurring Track

Mailing Address: 701 N. Columbia St.

City, State, Zip Code: Covington, LA 70433

Relationship: Treatment Team Telephone Number: (985)326-1718

☐ **RELEASE Information TO** or ☐ **OBTAIN Information FROM**

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

Name: Covington Behavioral Health

Mailing Address: 201 Greenbriar Blvd

City, State, Zip Code: Covington, LA 70433

Relationship: provider Telephone Number: 985-893-2970

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) Case Management/Continuity of Care

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: doctor's notes

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. I authorize a copy (including electronic or faxed copy) of this form for the disclosure of the information described above.

_____ _____
Signature of Individual or Personal Representative authorized by law Date

Please submit medical information to:

Heather O'Neill	case manager	
Agency Representative	**Title**	**Date**
985-326-1718	985-288-5773	honeill@stpgov.org
Telephone	**Fax**	**Email**