STATE OF LOUISIANA - OFFICE OF GROUP BENEFITS
RELEASE OF DEPENDENT CHILD
PROTECTED HEALTH INFORMATION (PHI)

Authorization Pursuant to 45 CFR 164.524(c)(4)

DEPENDENT CHILD NAME	/NICKNAME		
DEPENDENT CHILD SOCIAL SECURITY NUMBER	DATE OF BIRTH		
NAME OF HEALTH CARE PROVIDER AUTHORIZED TO MAKE THE REQUESTED DISCLOSURE TO OGB			
HEALTH CARE PROVIDER ADDRESS	CITY	STATE	ZIP CODE

I authorize you to disclose all protected health information to the Office of Group Benefits (OGB) for the purpose of determining my eligibility or my dependent child's eligibility (circle one) for continuing health care benefits coverage with OGB. I expressly authorize you to disclose full and complete medical information, including without limitation, any health care records, treatment (including those related to mental illness and/or AIDS/ARC/HIV, but excluding any psychotherapy notes in your possession), and/or medical equipment or supplies provided to me/my dependent child.	INITIALS
I understand and acknowledge that the covered entity to whom this authorization is directed may not condition my treatment, payment, enrollment or eligibility on whether or not I sign this authorization; however, pursuant to 45 CFR 154:508(b)(4)(ii), OGB may condition eligibility and enrollment determinations on whether I sign this authorization.	INITIALS
I authorize you to release information to the OGB and/or any independent claims administrators, consulting health care professionals, and/or utilization review organizations with whom OGB contracts.	INITIALS
I understand and acknowledge that I have a right to revoke this authorization at anytime by notifying you and OGB in writing; however, I understand that any actions already taken in reliance on this authorization cannot be reversed and my revocation will not affect those actions, including actions related to OGB's right to contest a claim.	INITIALS
I acknowledge the potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.	INITIALS
I agree that a photographic copy of this authorization is as valid as the original.	INITIALS
I understand that I may see and copy information described on this form if I ask it, and that I am entitled to a copy of this form after I sign it.	INITIALS
This authorization is valid for so long as I seek eligibility and/or enrollment determinations for continued health care benefits with OGB on my behalf and/or on behalf of my dependent child.	INITIALS

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Signature of Plan Member (Or His/Her Representative)

Date

If this form is signed by a personal representatitve, complete the following:

Printed Name of Plan Member's Representative

Relationship to Plan Member (Including authority to act as personal representative)