MHSD
METROPOLITAN HUMAN SERVICES DISTRICT

Authorization to Release or Obtain Health Information (Including paper, oral and electronic information)

Important Information about Authorization

Authorization means to give permission or approval. We need your authorization before we can use, disclose or release, or obtain your health information for some of our services.

An authorization is voluntary. To give us your authorization you would sign this form. If you agree to sign this form, you will be given a signed copy.

You do not have to sign this form. If you do not sign, you are still eligible to receive some services and payment for health care services.

At times your authorization is required by law or policy before some services can be delivered. If your authorization is required by law or by policy, we will use and disclose or release your health information as you have authorized on the signed form.

When required by law or policy, we may only obtain, use and disclose or release your health information if the required written authorization includes all required elements of a valid authorization.

You may be required to sign an authorization form before receiving research-related treatment.

You may be required to sign an authorization form before sharing your protected health information for disclosure or release to a third party. Example: In juvenile court proceedings where a parent is required to obtain a psychological evaluation on their minor child by MHSD, the parent may be required to sign an authorization to release the evaluation report (but not the psychotherapy notes) to the requesting court.

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

Information used, disclosed or released by this authorization may be re-disclosed or released by the recipient and will no longer be protected by our privacy policies.

NOTE: Metropolitan Human Services District does not release records received from other health/human services providers on your behalf.

Section A: General Information:

Name: _____ Request Date: 8/3/2023
Mailing Address: _____ Date of Birth: _____
City/State/Zip: _____ Medicaid ID # or Social Security #_____

I authorize:
Metropolitan Human Services District, 3100 Gen. De Gaulle Dr., New Orleans, LA 70114, (504)-568-3130, FAX: (504)942-8242
Relationship (service provider): _____

☐ **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: _____
Mailing Address: _____
City, State, Zip Code: _____
Relationship: _____ Telephone Number: _____ FAX #: _____

The Specific Purpose of this Authorization is indicated in the box(es) below. *(Place an "X" in the box(es) that apply.)*

☐ Continuity of Care ☐ Changing Physician ☐ Health Information for disclosure to third party ☐ Research related treatment
☐ I\DD Services ☐ Program Eligibility/Entry ☐ Legal Investigation or Action ☐ PASRR (Nursing Home Admission)
☐ Other (please specify) _____

Section B: Physical Health Information: ☒ Not applicable

I authorize the release of the following Protected Health Information.
(Place an "X" in the box that indicates if the information is being released OR requested.)

☐ Entire Record ☐ Immunizations ☐ Treatment/Tests ☐ I/DD Records ☐ Medical History (Examination/Reports)
☐ Prescriptions ☐ Surgical Reports ☐ X-Ray Reports ☐ Laboratory Reports ☐ Hospital Records (Including reports)
☐ Annual Physical Exam ☐ Other (please specify) _____

Section C: Addiction Information and Mental Health Information: ☒ Not applicable

In compliance with state and/or federal laws, which require special permission to release otherwise privileged information, please release the following records: *(Place an "X" in the box(es) that apply.)*

1. ADDICTION INFORMATION

☐ Alcoholism ☐ Dates of Care ☐ Treatment Recommendation ☐ Treatment Plan
☐ Alcohol Tests ☐ Discharge Summary ☐ Sexually Transmitted Diseases (STDs) ☐ Drug Tests
☐ Drug Use ☐ Intake Assessment (ASI) ☐ Vocational Rehabilitation ☐ Prescriptions
☐ HIV/AIDS ☐ Psychiatric Evaluation ☐ Aftercare Recommendations ☐ Medical Records
☐ Genetics ☐ Psychosocial Assessment ☐ Progress Notes (AD Therapy & Group) ☐ Other Lab Reports

2. MENTAL HEALTH INFORMATION

☐ Mental Health Record **without** Psychotherapy Notes ☐ Mental Health Record **with** Psychotherapy Notes
☐ Other (please specify) _____

Section D: Intellectual and Developmental Disabilities Information: ☒ Not applicable

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.)

☐ Entry Documentation ☐ Psychological Evaluation ☐ Statement of Approval/Denial
☐ Positive Behavioral Support Plan ☐ Plan of Support/Plan of Care
☐ Other (please specify) _____

This authorization shall expire on _____ (date or event) and covers 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 have been informed of my right to not disclose the information on pages 1 and 2. I agree and permit the above marked disclosures.

8/3/2023
_____ _____
Signature of Individual or Personal Representative as Authorized by Law Date

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

Employee _____ 2 Person served initials_____

Print Form