400 Poydras St., Suite 1950
New Orleans, LA 70130

T 504.322.3837
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Authorization to Release Health Information Pursuant to HIPAA (including paper, oral and electronic information)

I authorize:
Name: *Integrated Behavioral Health*

Mailing Address: *400 Poydras, Suite 1950*

City, State, Zip Code: *New Orleans, LA, 70130*

Relationship: *Medical Provider* Telephone Number: *504-322-3837*

☐ **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: _____

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 ☐ Treatment plans ☐ Prescriptions ☐ Laboratory Reports
☐ Other: _____

☐ I specifically authorize the release of the following types of highly confidential information: AIDS or HIV, Mental Health Information, and Sexually Transmitted Diseases.

☐ I understand that, unless action already has been taken in reliance on this authorization, I may revoke this authorization at any time by making a written request to Integrated Behavioral Health.

☐ I understand that signing this authorization is voluntary and that Integrated Behavioral Health, may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization, unless my treatment is related to research and the purpose of this authorization is to enable the protected health information described above to be used for such research.

☐ I understand that information disclosed based on this authorization may be subject to redisclosure by the recipient, and no longer protected by federal or state privacy regulations.

☐ I have received a copy of this authorization.

This authorization shall expire on _____ (date or event).
I understand that if I do not specify an expiration date, this authorization will expire twelve (12) months from the date on which it was signed. I acknowledge that I have this form.

_____ _____
Signature of Individual or Personal Representative Authorized by Law Date

_____ _____
Patient Name (printed) Date of Birth