ODYSSEY HOUSE LOUISIANA

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: Odyssey House Louisiana, Adult Residential Program
Mailing Address: 1125 N. Tonti St.
City/State/Zip Code: New Orleans , LA 70119
Relationship: Treatment Facility Telephone Number: 504-821-9211

☐ 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:_____

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)_____

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:_____

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 this form.

_____ _____
Signature of Client Date

_____ _____
Signature of Guardian Date

_____ _____
Signature of Staff Date