Consent to Release or Obtain Health Information
(including paper, oral and electronic information)

Name	**Request Date:**
Address	Date of Birth
City/State/Zip	Social Security #

I Authorize:

Name: Odyssey House Louisiana, Inc.
Address: 2700 S. Broad Street
City, State, Zip: New Orleans, LA 70125
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: _____

Address: _____

City/State/Zip: _____

Relationship: _____ Method of Delivery: Fax #_____ Email _____

The **Purpose of this Consent** 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:

❑ 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 (Specify):_____

This consent shall expire on _____ (date or event) and

is needed for the period beginning _____ and ending _____.

The information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I understand that I have the right to Revoke this consent at any time. I also understand that to Revoke this consent, I must complete and sign a "Revocation of Consent to Release Information" form.

_____ _____

Signature of Individual or Personal Representative Authorized by Law Date

Relationship: _____

_____ _____

Signature of Witness Date