

**City of New Orleans – Emergency Medical Services  
 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: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Relationship: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

**RELEASE Information TO**      or       **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.)

- Emergency Medical Services Patient Care Report
- Other (specify) \_\_\_\_\_

**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 both pages 1 and 2 of this form. I authorize a copy (including electronic or faxed copy) of this form for the disclosure of the information described above.

Signature of Individual or Personal Representative authorized by law \_\_\_\_\_ Date \_\_\_\_\_

**Please submit medical information to:**

_____	_____	_____
<b>Agency Representative</b>	<b>Title</b>	<b>Date</b>
_____	_____	_____
<b>Telephone</b>	<b>Fax</b>	<b>Email</b>

## Important Information about Authorization

We may need your authorization to use, disclose or obtain your health information for some of our services.

You do not have to sign this form. If you agree to sign this authorization to release or obtain information you will be given a copy of the signed form, upon request

A separate signed authorization form is required for the use and disclosure of health information for:

- ✓ Psychotherapy notes
- ✓ Employment-related determinations by an employer
- ✓ Research purposes unrelated to your treatment

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

- ✓ An authorization is voluntary. You will not be required to sign an authorization as a condition of receiving treatment services or payment for health care services. If your authorization is required by law or policy, New Orleans EMS will use and disclose your health information as you have authorized on the signed authorization form.
- ✓ You may be required to sign an authorization before receiving research-related treatment.
- ✓ You may be required to sign an authorization form for the purpose of creating protected health information for disclosure to a third party. *Example:* In a juvenile court proceeding where a parent is required to obtain a psychological evaluation on their minor child by DHH, the parent may be required to sign an authorization to release the evaluation report (but not the psychotherapy notes) to DHH.
- ✓ You may cancel an authorization in writing at any time. New Orleans EMS can not take back any uses or disclosures already made before an authorization was cancelled.
- ✓ Information used or disclosed by this authorization may be re-disclosed by the recipient and will no longer be protected by New Orleans EMS privacy policies.

### Your right to file a privacy complaint

You may contact the Privacy Office listed below if you want to file a complaint or to report a problem about how New Orleans EMS has used or disclosed information about you. Your benefits will not be affected by any complaints you make. New Orleans EMS cannot punish or retaliate against you for filing a complaint, cooperating in any investigation, or refusing to agree to something that you believe to be unlawful. Your Privacy office contact is:

#### Privacy Officer

**New Orleans Emergency Medical Services**

**2929 Earhart Boulevard**

**New Orleans, LA 70125**

**Phone: 504-658-2929**

**Fax: 504-658-2739**