



# Louisiana Health Access Program

1450 Poydras St, Suite 2136

New Orleans, LA 70112

Office phone: (504) 568-7474

Confidential fax: (504) 568-3157



## CONSENT FOR RELEASE OF INFORMATION

This is a consent for release of your information between the Louisiana Health Access Program (also known as LA HAP or Louisiana ADAP) and staff at the agency listed below for the purpose of coordinating benefits and enrollment through LA HAP. It is not required that you sign this document to receive LA HAP services. This form is used to release protected health information as required by Federal and State privacy laws.

Your consent allows both organizations (LA HAP and the agency listed below) to release or obtain your information to/from each other in order to complete your enrollment or recertification in LA HAP, to update your LA HAP client record, and to view your eligibility/enrollment record in LA HAP's Pharmacy Benefits Manager (PBM) data system.

Examples of information exchanged are, but are not limited to: insurance status, insurance information, income information, household composition, address and other contact information, medication claims, premium or cost-share payments, and medical status.

Agency \_\_\_\_\_

Agency Phone Number \_\_\_\_\_

Agency Mailing Address \_\_\_\_\_

Primary Case Manager \_\_\_\_\_

Client's Full Legal Name \_\_\_\_\_

Client's Date of Birth \_\_\_\_\_

Client's SSN \_\_\_\_\_

**This consent does not automatically renew.** It expires eighteen months from the effective date, but you may cancel it at any time by contacting LA HAP at 504-568-7474.

**I understand that by signing this release I am consenting to the exchange of my personal health information between LA HAP and the agency named above. This release is valid for one year from the date below, or I may cancel it by calling 504-568-7474 at any time.**

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date Signed (Effective Date)

If applicable:

\_\_\_\_\_  
Signature of client's legal representative if client is unable to sign

\_\_\_\_\_  
Printed name of client's legal representative if client is unable to sign

\_\_\_\_\_  
Phone number of client's legal representative if client is unable to sign