Louisiana Board of Social Work Examiners

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PATIENT CONSENT TO DISCLOSURE OF MEDICAL RECORDS AND INFORMATION

I, the undersigned, below-identified **PATIENT**, do hereby authorize all of my health care providers to disclose and furnish any and all information, records, and opinions, any reports or summaries thereof, whether in electronic form or otherwise, relating to my evaluation, diagnosis, treatment and prognosis by or under the care of the health care provider, to the Louisiana Board of Social Work Examiners, the Impaired Professional Program and any representatives thereof (collectively referred to as the "Board"), for the purpose of permitting the Board to be initially and periodically advised of my diagnosis, treatment and prognosis for any condition, including but not limited to alcoholism, drug abuse and/or a physical/mental condition, which may impair my capacity to practice social work with reasonable skill and safety to patients or to myself.

This Consent is made and given in conformity with and pursuant to 42 U.S.C. §290dd-2(b)(1) and former §290ee(3)(b)(1) and regulations promulgated thereunder, 42 C.F.R. §2.31-.33, as well as 42 U.S.C. § 1320d *et seq.* and regulations promulgated thereunder, 45 C.F.R. Part 164, but is intended to be effective to consent to the disclosures authorized herein whether or not the health care provider is subject to the provisions of 42 C.F.R. Part 2 or 45 C.F.R. Part 164.

I understand that the provision of treatment or health care may not be conditioned on my signing this Consent. I further understand that there is the potential that protected health information is disclosed pursuant to this Consent may be redisclosed by the recipient and that the protected health information will no longer be protected by the federal privacy regulations.

This Consent is subject to revocation at any time except to the extent that the program to which this disclosure has been made has already taken action in reliance on it. If not previously revoked, this Consent will be effective until termination of this Consent Order/Agreement not to exceed five (5) years.

_____
Signature of Patient

_____
Signature of Patient's Representative (if necessary)

_____
Date

PATIENT

Name:_____

Social Security #:_____

Address:_____

_____

_____

_____

Phone:_____