LOUISIANA DEPARTMENT OF HEALTH

Authorization to Release Health Information

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

I authorize: Louisiana Department of Health (628 N 4th St., Baton Rouge, LA 70802)

TO RELEASE Information TO

Department of Public Safety / Louisiana State Police / Concealed Handgun Permit Unit / Sgt. Arman Douglas
7919 Independence Blvd., Baton Rouge, LA 70806

The **Purpose of this Authorization** is: Evaluation of application for concealed handgun permit

I authorize the release of any health information in the possession of the Louisiana Department of Health concerning the following:

ALCOHOLISM, SUBSTANCE ABUSE DISORDER (DRUG ABUSE), MENTAL HEALTH

This authorization shall expire at expiration of permit or denial of application and subsequent delays for review pursuant to LAC 55:I.1315

_____ _____

Signature of Individual or Personal Representative Authorized by Law — Date

_____ _____

Signature of Witness *(only if signed with an "X" or mark above)* — Date

Important Information about Authorization

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

You may revoke and /or cancel an authorization at any time. LDH cannot take back any uses or disclosures already made before an authorization was cancelled. Revocation need not be made in writing.

Information used or disclosed by this authorization may not be re-disclosed by DPS-LSP.