AFFIDAVIT of FACT

STATE OF LOUISIANA PARISH OF ______________________________

____
Affiant's Name (Printed)

____
Affiant's Address (Printed)

I, ______________________________, having been duly sworn, depose and say that I have read the foregoing application, and the contents thereof, and do hereby certify that my responses and information contained within this application are true and correct and they are an accurate account of the requested information. In addition, I have also read, understand, and agree to comply with the statutes contained in R.S. 40:1379.3 and 1382, and the corresponding administrative regulations contained in LAC 55:I:1301 et seq. I have executed this statement voluntarily with the knowledge that any failure to provide truthful information is cause for denial of my application or revocation of a permit, and that the making of any false statement or response in this application is a violation of R.S. 14:133, Filing False Public Records, a criminal offense punishable by imprisonment for not more than five (5) years with or without hard labor or a fine not to exceed five thousand dollars, or both.

____
Affiant's Signature

SWORN TO AND SUBSCRIBED BEFORE ME ON THIS _____________ DAY OF ________________, ___________

____ ____
Print, Type, or Stamp Name of Notary Public **Notary Public**

MY COMMISSION EXPIRES ___________________________________

Affidavits are valid for sixty days after notarization.

B	*INDEMNIFICATION AND HOLD HARMLESS AFFIDAVIT*

STATE OF LOUISIANA PARISH OF ______________________________

BEFORE ME, the undersigned Notary Public, duly commissioned and qualified, in and for the Parish and State aforesaid, personally came and appeared:

____
Affiant's Name (Printed)

____
Affiant's Address (Printed)

Who being by me first duly sworn, deposed and said:

I, ________________________________, pursuant to R.S. 40:1379.3, agree to indemnify and hold harmless the state of Louisiana, the Department of Public Safety and Corrections, the Secretary and the Deputy Secretary of the Louisiana Department of Public Safety and Corrections, and any of its agents or employees, and any peace officer within this state, from and against any and all liability, claims, actions, fines or losses of any kind or nature, including costs and attorney's fees, in any way arising out of, connected with or related to the issuance or use of my Louisiana Concealed Handgun Permit.

____
Affiant's Signature

SWORN TO AND SUBSCRIBED BEFORE ME ON THIS ____________ DAY OF _______________, ___________

____ ____________________________________
Print, Type, or Stamp Name of Notary Public **Notary Public**

MY COMMISSION EXPIRES ________________________________

Affidavits are valid for sixty days after notarization.

C

AUTHORIZATION FOR RELEASE OF MEDICAL AND PERSONAL INFORMATION

STATE OF LOUISIANA PARISH OF ______________________________

TO: Any physician, psychologist, social worker, hospital, clinic, or other health care provider, law enforcement Agency or officer, any branch of the Armed Forces of the United States, or any individual or institution having information about me.

BEFORE ME, the undersigned Notary Public, duly commissioned and qualified, in and for the Parish and State aforesaid, personally came and appeared:

____

Affiant's Name (Printed)

____

Affiant's Address (Printed)

Who being by me first duly sworn, deposed and said:

I, ____________________________, do hereby give my consent in authorizing full disclosure and review of all records and information, verbal or written, concerning myself to any duly authorized agent of the Louisiana Department of Public Safety and Corrections, Office of State Police, Concealed Handgun Permit Section, whether said records are public, private, confidential, or privileged in nature. I further understand that if any of the records obtained are confidential or privileged, the Louisiana Department of Public Safety and Corrections will maintain the privilege or confidentiality of such records.

The intent of this authorization is to give my consent for full and complete disclosure of any and all medical, criminal, or other personal information regarding me, including but not limited to physical, psychiatric, or substance abuse treatment and/or consultation records, and all records pertaining to my conduct such as background reports, criminal history records, etc. I further understand that this release will only be used to obtain information for the purpose of determining my eligibility for a Louisiana Concealed Handgun Permit.

I understand that any information obtained through a medical or personal history background investigation which is developed directly or indirectly, in whole or in part, upon this release authorization will be considered in determining my eligibility for a concealed handgun permit. I also certify that any person(s) who may furnish such information concerning me shall not be held liable for giving this information, and I do hereby release said person(s) from any and all liability which may be incurred as a result of furnishing such information.

I also understand that a reproductive copy of this release affidavit shall be for all intents and purposes as valid as the original. I request and appreciate your full cooperation.

This release shall be and remain valid from the date of execution until the expiration or revocation of any concealed handgun permit issued to me pursuant to this application, or until my application for a concealed handgun permit has been denied pursuant to a final judicial decision.

____

Affiant's Signature

SWORN TO AND SUBSCRIBED BEFORE ME ON THIS ____________ DAY OF ________________, ___________

____ ____

Print, Type, or Stamp Name of Notary Public **Notary Public**

MY COMMISSION EXPIRES ________________________________

Affidavits are valid for sixty days after notarization.

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:

""'CNEQJ QNKUO ."UWDUVCPEG'CDWUG'FKUQTFGT"*FTWI "CDWUG+."OGPVCN'J GCNVJ

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.