Health Care Component: ______________________

Unit Privacy Officer: __________________________

Authorization for Disclosure of Patient Medical/Health Information

Instructions: Please print then sign the form.

I,(Name of Patient, Parent, Guardian/Legal Representative) __________________, authorize and request Missouri State Health Care Component (Name of Component to Release Information) __________________ to disclose/release the below specified information of (Name of Patient) __________________, (Date of Birth) __________________, (Social Security Number) __________________, who received services from (Date) __________________ to (Date) __________________ from:

Name of indicated Facility, Agency, Mental Health Center, Person to Whom Disclosure is to be Made:

____

Address: __________________________

City, State, Zip Code: ____

INFORMATION REQUESTED: I hereby agree to this authorization and understand that it must contain Personally Identifiable Information and PHI as defined by HIPAA to ensure accuracy. I understand I have the right to limit the type of information released and to revoke this authorization which will EXPIRE in one year. If I choose to limit the information released, I understand that HCC may inform the requestor that portions of the record have been withheld.

Please circle either ALL or PARTIAL.

ALL medical records without exception, including: clinical notes, letters, x-ray reports, lab testing (including HIV), mental health counseling and treatment, al.cohol or drug abuse testing and treatment, consultations, secondary records, etc.

PARTIAL medical records. Please specify parts and dates to be released.

Progress notes	__________________	Immunizations	__________________
X-ray reports	__________________	Allergy	__________________
Lab reports	__________________	Physical	__________________
Gyn records	__________________	Consultations	__________________
Other	__________________		

for the purpose of ____

1. **READ CAREFULLY**: I understand that my medical/health information records are confidential. I understand that by signing this authorization, I am allowing the release of my medical/health information. The protected health information (PHI) in my medical record includes mental/behavioral health information. In addition, it may include information relating to sexually transmitted diseases, acquired

immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), other communicable diseases, and/or alcohol/drug abuse.

2. Alcohol and drug abuse information records are specifically protected by federal regulations (42 CFR 2) and by signing this authorization without restrictions I am allowing the release of any alcohol and/or drug information records (if any) to the agency or person specified above. Please sign if you are authorizing the release of alcohol and drug abuse information.

I hereby release drug and alcohol abuse information.

_________________________ ___ /___ /___
Signature Date

3. This authorization includes both information presently compiled and information to be compiled during the course of treatment at the above-named facility during the specified time frame.

4. This authorization becomes effective on ____________________. This authorization automatically expires on the following date, event or special condition ____________________.

5. If I fail to specify an expiration date, this authorization will expire in one (1) year.

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so ***in writing*** and present my written revocation to the health information management department (medical records) or client information center at this facility. I further understand that actions already taken based on this authorization, prior to revocation, will ***not*** be affected.

7. I understand that I have the right to receive a copy of this authorization. A **photographic copy of this authorization is as valid as the original**.

8. I understand that authorizing the disclosure of this medical/health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may request to inspect or request a copy of information to be used or disclosed, as provided in 45 CFR § 164.524. I understand that any disclosure of information carries with the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my medical/health information, I can contact the Missouri State Health Care Component Director, or designee, or the Privacy Officer for this HCC.

9. **THE FOLLOWING STATEMENT APPLIES TO ANY ALCOHOL AND/OR DRUG ABUSE TREATMENT INFORMATION RECORDS THAT WE DISCLOSE:** Prohibition on Redisclosure: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making further disclosure of it without the specific written authorization of the person to whom it pertains, or as otherwise specified by such regulations. A general authorization for disclosure of medical or other information is NOT sufficient for this purpose.

My signature below acknowledges that I have read, understand, and authorize the release of my PHI.

____ /___ /___
Signature of Patient Date
____ /___ /___
Signature of Witness Date
____ /___ /___
Signature of Parent/Legal Guardian/Representative Date

NOTICE OF REVOCATION

I, ____________________, hereby revoke my authorization of this disclosure of information to the agency/person listed above. This revocation effectively makes null and void any permission for disclosure of information expressly given by the above authorization. I understand that any actions based on this authorization, prior to revocation, will not be affected.

____ /___ /___
Signature of Patient Date

____ /___ /___
Signature of Witness Date

____ /___ /___
Signature of Parent/Legal Guardian/Representative Date

If you choose to revoke your authorization, please provide a copy of the completed revocation to the Missouri State Health Care Component, or the HCC Privacy Officer.

A copy of this form will be filed in the above-named patient's PHI.

HIPAA Procedure 1.050, Form 1