STATE OF MISSOURI

AUTHORIZATION FOR DISCLOSURE OF CONSUMER MEDICAL/HEALTH INFORMATION

I, _____

(NAME OF CONSUMER, PARENT, GUARDIAN/LEGAL REPRESENTATIVE)

authorize and request

Check all that apply:

☐ Department of Mental Health (DMH)

☐ Department of Health and Senior Services (DHSS)

☐ Department of Social Services (DSS)

☐ Department of Elementary and Secondary Education (DESE)

☑ Other _____

(NAME OF FACILITY, AGENCY, MENTAL HEALTH CENTER, PERSON)

to **disclose/release** the below specified information of:

NAME	DCN
DATE OF BIRTH	SOCIAL SECURITY NUMBER
WHO RECEIVED SERVICES FROM (DATES)	

to **(check all that apply)**

☐ Department of Mental Health (DMH)

☐ Department of Health and Senior Services (DHSS)

☐ Department of Elementary and Secondary Education (DESE)

☑ Department of Social Services (DSS)

☑ Other FSD / Medical Review Team - Processing Center
(NAME OF FACILITY, AGENCY, MENTAL HEALTH CENTER, PERSON)

101 PARK CENTRAL SQUARE, SPRINGFIELD, MO 65806
(ADDRESS, CITY, STATE, ZIP)

THE PURPOSE OF THIS DISCLOSURE IS (CHECK ALL THAT APPLY)

☑ Eligibility Determination ☐ Assessment

☐ Aftercare ☐ Placement ☐ Transfer/Treatment

☐ Treatment Planning ☐ Continuity of Services/Care

☐ Conditional/Unconditional Release Hearing

☐ At Consumer's Request

☑ To share or refer my information to other Missouri state agencies (such as DMH, DHSS, DSS, DESE, etc.) to obtain services consistent with the Mo Health Net Aged, Blind, or Disabled program (please complete the name of the program in which you want to participate)

☐ Other (specify) _____

☐ Do a general medical evaluation, psychological evaluation, orthopedic evaluation, or _____ Evaluation, and complete the enclosed IM-60A. The examination may include test (s) which are indicated by the patient's complaints and are necessary before you can reach a decision on his/her employability. The examination is scheduled for

_____at

_____. The Family Support Division will honor a physician's usual and customary charges, up to but not exceeding our professional reimbursement schedule. If, in your opinion, the patient must be hospitalized in order for you to complete this medical report, Prior Written Authorization by the State Medical Review Team must be given before payment will be made by the Family Support Division.

THE SPECIFIC INFORMATION TO BE DISCLOSED IS (CHECK ALL THAT APPLY)

- ☐ Discharge Summary
- ☐ Progress Notes
- ☐ Treatment Plan and/or Review
- ☐ Social Service Assessment
- ☐ Educational testing, IEP, transcript, and/or grading reports
- ☐ Medical/Psychiatric Assessment(s), and complete the certification section of the enclosed IM-60a.
- ☐ Psychometric testing, including intelligence quotient (IQ) results, neurological testing, or other developmental test results.
- ☐ Other **CLINICS ONLY:** All clinic records for requested time period
- ☐ Hospital's Pertinent data: History and Physical, Discharge Summary, Consultative exams, Lab reports, Radiology reports including MRI and CT scans, Cardiology Records, Operative Reports, Pathology Reports, and Emergency Room Records

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:

_____

_____

3. This authorization includes both information presently compiled and information to be compiled during the course of treatment at the above-named facility or agency paying for services, 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 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 of disclosed, as provided in 45 CFR Section 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 health information management director (medical records director) or client information center, or designee, or the Privacy Officer for this covered entity.

THE FOLLOWING APPLIES TO ALCOHOL AND/OR DRUG ABUSE TREATMENT INFORMATION RECORDS: Prohibition of 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 regulation. 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 CONSUMER
DATE
WITNESS
DATE
SIGNATURE OF PARENT/LEGAL GUARDIAN/REPRESENTATIVE

(Please include a Description of Authority to Act on Consumer's Behalf and attach a copy of the Document Granting Authority, where applicable)

NOTICE OF REVOCATION

DATE

I, _____, (Consumer) 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 CONSUMER

DATE

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 health information management director (medical records director), or the client information center, or to the Privacy Officer of this facility.

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