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MISSOURI DEPARTMENT OF SOCIAL SERVICES - FAMILY SUPPORT DIVISION

# AUTHORIZATION FOR RELEASE OF MEDICAL/HEALTH INFORMATION NURSING FACILITIES, IN-HOME NURSING CARE PROVIDERS, AND OTHER PROVIDERS OF MEDICAL SERVICES

I _____do hereby authorize and request that the State of Missouri, Department of Social Services, Family Support Division, release or disclose to the following organization or person: _____ *(person/organization name)* at_____*(address)*, _____ *(telephone number)*, the financial and health information of the person listed below:

| NAME ON INFORMATION TO BE DISCLOSED | BIRTH DATE | SOCIAL SECURITY NUMBER OR DCN |
|---|---|---|
| | | |

**THE SPECIFIC INFORMATION TO BE DISCLOSED IS ALL FINANCIAL AND MEDICAL INFORMATION OF THE ABOVE NAMED INDIVIDUAL, INCLUDING, BUT NOT LIMITED TO, DOCUMENTS AND INFORMATION NECESSARY TO COMPLETE THE FOLLOWING PURPOSES.**

THE PURPOSE OF THIS REQUEST IS TO:

- ☐ ASSIST WITH APPLICATION FOR MO HEALTHNET BENEFITS
- ☐ ASSIST WITH RENEWAL OF ELIGIBILITY FOR MO HEALTHNET BENEFITS
- ☐ ASSIST WITH POSSIBLE CHANGES IN ELIGIBILITY FOR MO HEALTHNET BENEFITS

## YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

You cannot be required to sign this disclosure authorization form. Your MO HealthNet application will not be denied if you do not sign this form. If you do not sign this form, your benefits could be delayed because necessary information may not be promptly provided to Family Support Division. If you do sign this form, you must be given a copy. You have the right to inspect the information to be disclosed and you may revoke this authorization at any time by writing the facility named above and the DSS Privacy Officer at PO Box 1527, Jefferson City, MO 65102. A revocation of this authorization will not reverse disclosures of information already made under the authorization. You understand that once information is released to the above named facility or individual specified above, your information may be subject to re-disclosure. Alcohol and drug abuse treatment records are specifically protected by federal regulations (42 CFR Part 2) and by signing this authorization, without restriction, you are allowing the release of all medical records including any alcohol and/or drug records that may be in your files to the above named facility or individual specified above. If you do not want your alcohol and/or drug records released, initial in the following box: ☐

## SIGNATURE

I have had an opportunity to review and understand the content of this authorization form, and by signing this authorization, I confirm it accurately reflects my wishes. **Note: If a guardian, legal representative or a personal representative signs this document; they must provide separate documentation of their status and authority to sign this authorization to the Family Support Division along with the signed authorization.**

| SIGNED (INDIVIDUAL, GUARDIAN, LEGAL OR PERSONAL REPRESENTATIVE) | DATE |
|---|---|
| | |

ADDRESS

**EXPIRATION DATE** – This authorization is good until _____ or one year from signature if no date entered.

## PLEASE RETURN REQUESTED INFORMATION TO FOLLOWING HCBS PROVIDER OR NURSING HOME UNIT:

| OFFICE | TELEPHONE NUMBER |
|---|---|
| | |

ADDRESS

PLEASE PROVIDE AN E-MAIL ADDRESS