Missouri Department of SOCIAL SERVICES
Your Potential. Our Support.

RESET

AUTHORIZATION FOR RELEASE OF MEDICAL/HEALTH INFORMATION

I, _____ do hereby authorize and request
(NAME OF INDIVIDUAL, GUARDIAN, LEGAL OR PERSONAL REPRESENTATIVE)

that _____ release or disclose to
(NAME OF ENTITY OR INDIVIDUAL **HOLDING THE RECORDS**)

_____
(NAME OF INDIVIDUAL OR ENTITY TO RECEIVE THE RECORDS) (ADDRESS)

the health information for the individual listed below.

NAME ON INFORMATION TO BE DISCLOSED	BIRTH DATE	SOCIAL SECURITY NUMBER

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

☐ Entire Record
☐ Laboratory Reports
☐ Psychological Evaluation
☐ Medical History, Examinations, Diagnosis
☐ Hospital Records Including Reports
☐ Mental Health Records/Reports
☐ Healthcare Payments
☐ Other (Specify): _____

Dates of Service, if appropriate: _____

PURPOSE OF REQUEST FOR DISCLOSURE

☐ At the request of the individual or the individual's legal representative

☐ Other (Specify): _____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

You can not be required to sign this disclosure authorization form nor may treatment or payment be refused if you do not sign, but if you 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 by writing the DSS Privacy Officer at PO Box 1527, Jefferson City, MO 65102. A revocation of this authorization will not reverse disclosures already made under this authorization and when a disclosure occurs, there is a possibility the information might be re-disclosed by the recipient. For more information you may call 573-751-3229. (TDD 800-735-2966 or 800-735-2466)

Alcohol and drug abuse treatment records are specifically protected by federal regulations (42 CFR 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 entity or individual specified above. If you want to restrict this authorization to not include alcohol and drug abuse treatment records, please initial 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.**

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

ADDRESS

EXPIRATION DATE - This authorization is good until the date(s) _____ or for one year.

PLEASE RETURN REQUESTED INFORMATION TO

WORKER'S NAME	TELEPHONE NUMBER

ADDRESS (STREET, CITY, STATE, ZIP CODE)

Submit