Department of Social Services

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION BY DSS EXHIBIT 2

INDIVIDUAL:

____________________ Name of Individual/Previous Names

____________________ Birth Date

____________________ Social Security Number

____________________ Other identifier (e.g., DCN)

____________________ Street Address

____________________ City, State, Zip

AUTHORIZES DSS TO RELEASE HEALTH INFORMATION TO:

____________________ Name of Health Care Provider/Plan/Other

____________________ Name of Health Care Provider/Plan/Other

____________________ Street Address

____________________ Street Address

____________________ City, State, Zip Code

____________________ City, State, Zip Code

INFORMATION TO BE RELEASED: For the Following Date(s): ____________________

___ Medical History, Examination, Reports
___ Treatment or Tests
___ Allergy Records
___ Consultations
___ Claims Information
___ Surgical Reports
___ Hospital Records Including Reports
___ Laboratory Reports
___ Entire Record
___ Immunizations
___ X-ray Reports
___ Prescriptions
___ Medical Diagnosis
___ Other (Specify): ____________________

PURPOSE OF REQUEST FOR DISCLOSURE:

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

___ Other (Specify): ____________________

EXPIRATION DATE: This authorization is good until the date(s) ____________________or for one year from the date signed.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATON:

Right to Inspect or Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information. **Right to Receive A Copy of This Authorization -** I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. **Right to Refuse to Sign This Authorization -** I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. I understand that there is a potential for the information to be redisclosed by the recipient. **Right to Withdraw This Authorization-** I understand that I may revoke this authorization in writing to the DSS Privacy Officer. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization. **Notice of Privacy Practices –** I understand that I may request a copy of the DSS Notice of Privacy Practices in writing to the DSS Privacy Officer.
For information regarding any of the above, you may contact the DSS Privacy Officer at PO Box 1527, Jefferson City, MO 65102 (VOICE: 1-800-735-2466) (TEXT: 1-800-735-2966).

SIGNATURE OF INDIVIDUAL/PERSONAL REPRESENTATIVE: I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

____________________**DATE:** ____________________

(If signed by other than individual, state relationship and authority to do so.)

Individual is: ! Minor ! Incompetent ! Disabled ! Deceased

Legal Authority: ! Custodial Parent ! Legal Guardian ! Executor of Estate of Deceased ! Power of Attorney for Healthcare ! Authorized Legal Representative