Department of Social Services
AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION BY DSS

**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