MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

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

I, _____ (Individual, guardian, legal representative, or a personal representative's name) do hereby authorize and request that the State of Missouri, Department of Social Services, Family Support Division, release or disclose the financial and health information of the person listed below:

Name on Information to be Disclosed	Date of birth	Social Security Number or DCN

The information is to be released to the following organization or person:

Organization/Person

Address

Phone Number	Email Address

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 and necessary information is not promptly provided to Family Support Division, your benefits could be delayed.
- If you do sign this form, you can request a copy.
- You have the right to inspect the information to be disclosed.
- You understand that once information is released to the above named facility or individual specified above, your information may be subject to re-disclosure.
- 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.
- This authorization will remain effective until it is revoked in writing by the participant or their representative, the day after an application is complete (if authorized only to assist with an application for MO HealthNet), or the participant's death.

- 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.

If submitting electronically – I have agreed to submit this form by electronic means. I understand that an electronic signature has the same legal effect and can be enforced in the same way as a written signature. ☐ I agree

Signature	Date

Address

Phone Number	Email Address

Please return requested information to following HCBS provider or Nursing Home Unit:

Office	Telephone Number

Address

Email Address