Attachment 3

MISSOURI DEPARTMENT OF SOCIAL SERVICES

CONSUMER’S AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

|  |  |  |  |
| --- | --- | --- | --- |
| I, authorize and request  (NAME OF CONSUMER, PARENT, GUARDIAN/LEGAL REPRESENTATIVE)  **Check all that apply:**  Department of Social Services (DSS) Family Support Division (FSD)  Division of Youth Services (DYS) Children’s Division (CD)  MO HealthNet Division (MHD) Division of Legal Services (DLS) Division of Finance & Administrative Services (DFAS)  Missouri Medicaid Audit and Compliance (MMAC)  Other  (NAME OF FACILITY, AGENCY, MENTAL HEALTH CENTER, PERSON)  to **disclose/release** the below specified information of: | | | |
| NAME | PHONE NUMBER | DATE OF BIRTH | SOCIAL SECURITY NUMBER |
| ADDRESS | | EMAIL ADDRESS | |
| to **(check all that apply)**  Attorney: Employer: Legislator: Governor’s Staff:  Other  (NAME OF FACILITY, AGENCY, PERSON)  (ADDRESS, CITY, STATE, ZIP) | | | |
| **THE PURPOSE OF THIS DISCLOSURE IS (CHECK ALL THAT APPLY)** | | | |
| Eligibility Determination Legal Consultation/Representation Legal Proceedings Employment Compliant/Investigation/Resolution Treatment Planning Continuity of Services/Care Background Investigation At Consumer’s Request To share or refer my information to other Missouri state agencies (such as DMH, DHSS, DSS, DESE, etc.) to obtain  services consistent with the program (please complete the name of the program in which you want to participate)  Other (specify) | | | |
| **THE SPECIFIC INFORMATION TO BE DISCLOSED IS (CHECK ALL THAT APPLY)** | | | |
| Entire File Hotline Investigations Eligibility Determinations Licensure Information Home Studies Substance Abuse Treatment  Medical/Psychiatric Evaluation/Treatment Records Client Employment Records  (NOTE: THIS DOES NOT INCLUDE THE RELEASE OF  Benefits Received EMPLOYMENT RECORDS FOR DSS EMPLOYEES)  Other | | | |

|  |  |
| --- | --- |
| 1. **READ CAREFULLY:** I understand that my information and records with the Department of Social Services are confidential by law. I understand that by signing this authorization, I am allowing the release of any and all of my information and records which I am authorized to receive as specified on this document whether past, present or created in the future up to the expiration or revocation date of this authorization, unless otherwise indicated. The protected information in my records may include medical treatment and/or evaluation information, mental/behavioral health information, information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), other communicable or environmental diseases and conditions, application for and/or receipt of public assistance benefits, alcohol/drug abuse information, and/or information concerning child abuse and neglect. 2. This authorization includes both information presently compiled and information to be compiled during your association or dealings with the Department of Social Services, during the specified time frame. 3. Unless otherwise indicated, this authorization becomes effective on the date of signature below and will expire one year from that date. 4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so **IN WRITING** and present my written revocation to the Privacy Officer of the Department of Social Services at P.O. Box 1527, Jefferson City, MO 65102. I further understand that actions already taken based on this authorization, prior to revocation, will **NOT** be affected. 5. I understand that I have the right to receive a copy of this authorization. **A photographic copy of this authorization is as valid as the original.** 6. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to receive services from the Department of Social Services. I understand that I may request to inspect or request a copy of information to be used or disclosed, as provided in 45 CFR Section 164.524. I understand that any disclosure of information carries with it the potential for redisclosure by the party receiving it and that the information may no longer be protected by law once it is in possession of the receiving party. If I have questions about disclosure of my information, I can contact the Privacy Officer of the Department of Social Services, my caseworker or designee. | |
| My signature below acknowledges that I have read and understood the text above, and authorize the release of my confidential information. | |
| SIGNATURE OF CONSUMER | DATE |
| WITNESS | DATE |
| SIGNATURE OF PARENT/LEGAL GUARDIAN/REPRESENTATIVE (IF APPLICABLE) | |
| (Please include a Description of Authority to Act on Consumer’s Behalf and attach a copy of the Document Granting Authority, where applicable.) | |
| **SURVEYS** | |
| Family Support Division would like to know what services enrolled participants are seeking from our programs. In an effort to capture this data, Family Support Division is administering a survey through Survey Monkey. Please select the preferred method of survey delivery:  Email Address Online  If you would like to take the survey online visit: <https://www.surveymonkey.com/r/C95SDWX> | |
| **NOTICE OF REVOCATION** | |
| DATE | |
| I, , (Consumer) hereby revoke my authorization of this disclosure of information to the agency/person listed above. This revocation effectively makes null and void any permission for disclosure of information expressly given by the above authorization. I understand that any actions based on this authorization, prior to revocation, will not be affected. | |
| SIGNATURE OF CONSUMER | DATE |
| WITNESS | DATE |
| SIGNATURE OF PARENT/LEGAL GUARDIAN/REPRESENTATIVE (IF APPLICABLE) | DATE |
| If you choose to revoke your authorization, please provide a copy of the completed revocation to the Privacy Officer of the Department of Social Services at P.O. Box 1527, Jefferson City, MO 65102. | |