Authorization for Disclosure of Consumer Medical/Health Information

I, _____ authorize and request
(Name of Consumer, Parent, Guardian/Legal Representative)

[x] Department of Mental Health [ ] Department of Social Services [ ] Department of Health and Senior Services

[x] Department of Elementary and Secondary Ed [x] Other Private Physicians or social service agencies

Indicate school district: _____

to **disclose/release** the below specified information of (name) _____

(date of birth): _____ (Last four digits of social security number) _____

who received services from _____ To _____
(Date) (Date)

to:

[ ] Department of Mental Health [ ] Department of Social Services [ ] Department of Health and Senior Services

[ ] Department of Elementary and Secondary Ed [X] Other **Pathways to Independence**
(Name of indicated Facility, Agency, Mental Health Center, Person)

200 S. Hanley Road, Suite 103
(Address)

Clayton, MO 63105
(City, State, Zip)

The Purpose of this Disclosure is:

[ ] Aftercare [ ] Placement [ ] Transfer/Treatment [ ] Treatment Planning [ ] Assessment [x] Consumer Request
[ ] Conditional/Unconditional Release Hearing [x] Eligibility Determination [ ] Continuity of Services/Care
[ ] To share information with above agencies to obtain services consistent with _____
Name of program

[x] Other specify To meet criteria to receive funding for pre-employment/recreation/leisure program and support

The Specific Information to be Disclosed is:

[ ] Discharge Summary [x] Treatment Plan and/or Reviews [x] Medical/Psychiatric Assessment(s)
[ ] Progress Notes [ ] Social Service Assessment
[x] For MR-DD, testing: psychometric, neurological, IQ results, or other developmental test results
[x] Educational Testing, IEP, transcript, grading reports
[x] Other - **(1) DMH #; (2) Diagnosis of disability; (3) address; (4) current residence type; (5) proof of substantial functional limitations in two or more of the following areas of major life activities: A. self-care, B. receptive and expressive language development and use, C. learning, D. self-direction, capacity for independent living or economic self- sufficiency, E. mobility. (MOCABI results or statement of limitations if applicable); and (6) Full Scale I.Q. Information/school records**

1. **READ CAREFULLY:** I understand that my medical/health information records are confidential. I understand that by signing this authorization, I am allowing the release of my medical/health information. The protected health information (PHI) in my medical record includes mental/behavioral health information. In addition, it may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), other communicable diseases, and/or alcohol/drug abuse.
2. Alcohol and drug abuse information records are specifically protected by federal regulations (42 CFR 2) and by signing this authorization without restrictions I am allowing the release of any alcohol and/or drug information records (if any) to the agency or person specified above. Please sign if you are authorizing the release of alcohol and drug abuse information: _____

3. This authorization includes both information presently compiled and information to be compiled during the course of treatment at the above-named facility during the specified time frame.

4. This authorization becomes effective on _____ This authorization automatically expires on the following date, event or special condition _____

5. If I fail to specify an expiration date, this authorization will expire in one year.

6. 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 health information management department (medical records) or client information center at this facility. I further understand that actions already taken based on this authorization, prior to revocation, will **not** be affected.

7. 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.**

8. I understand that authorizing the disclosure of this medical/health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. 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 the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my medical/health information, I can contact the health information management director (medical records director) or client information center, or designee, or the Privacy Officer for this covered entity.

9. **THE FOLLOWING STATEMENT APPLIES TO ANY ALCOHOL AND/OR DRUG ABUSE TREATMENT INFORMATION RECORDS THAT WE DISCLOSE:** Prohibition on Redisclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibit you from making further disclosure of it without the specific written authorization of the person to whom it pertains, or as otherwise specified by such regulations. A general authorization for disclosure of medical or other information is NOT sufficient for this purpose.

Signature of Consumer: _____ **Date:** _____

Signature of Witness: _____ **Date:** _____

Signature of Parent/ Legal Guardian/Representative: _____ **Date:** _____

(Please include a Description of Authority to Act on Consumer's Behalf):

NOTICE OF REVOCATION

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:** _____

Signature of Witness: _____ **Date:** _____

Signature of Parent/ Legal Guardian/Representative: _____ **Date:** _____

If you choose to revoke your authorization, please provide a copy of the completed revocation to the Health Information Management Director (Medical Records Director), or the Client Information Center, or to the Privacy Officer of this facility.