AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION
(INSTRUCTIONS ON REVERSE)

1

PATIENT NAME: _____
LAST FIRST MI MAIDEN OR OTHER FORMER NAME
DATE OF BIRTH: _____ SSN: _____ DAY PHONE: _____ EVENING PHONE: _____
MO DAY YR
ADDRESS: _____ CITY: ____ STATE: _____ ZIP: _____

2

I HEREBY AUTHORIZE (INSERT MEDICAL PROVIDER'S INFORMATION):

NAME: _____
ADDRESS: _____
_____
CITY: _____ STATE: _____ ZIP: _____
PHONE: _____ FACSIMILE _____

TO DISCLOSE MY PROTECTED HEALTH INFORMATION TO:

DISABLED CITIZENS ALLIANCE FOR INDEPENDENCE
C/O DATA ENTRY DEPARTMENT
P.O. BOX 675
VIBURNUM, MISSOURI 65566
TELEPHONE: (573)244-5706 FACSIMILE: (573) 244-5880

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INFORMATION TO BE RELEASED FOR THE TIME PERIOD BEGINNING _____ THROUGH THE PRESENT:

____ ENTIRE MEDICAL RECORD (including ER records, admission and discharge summaries, dictated reports and consults, operative and procedure reports, intraoperative and procedure flow sheets, informed consents, physician orders, progress notes, flow sheets, medication and transfusion records, test results, labs, pictures, pathology reports, EKGs, fetal monitoring strips, office records, immunization records growth charts, telemetry strips, radiology and other diagnostic reports, patient instructions, discharge summary).

____ RECORD ABSTRACT (History and physical, progress notes, lab, radiology, operative report, pathology report, consultation report and diagnostic tests).

____ RADIOLOGY AND OTHER DIAGNOSTIC IMAGING FILM, PICTURES, AND OR CD ROM (x-rays, CT scans, MRI, ultrasound, angiogram, diagnostic procedure, etc.,) unless otherwise specified.

____ ALL MEDICAL AND RELATED BILLS RELATED TO THE ABOVE REQUESTED INFORMATION

____ MEDICATION RECORDS

____ OTHER (SPECIFY CONTENT): HOSPITALIZATION/INSTITUTION ADMISSION AND DISCHARGE DATES.

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I SPECIFICALLY AUTHORIZE THE RELEASE OF INFORMATION TO THE ABOVE NAMED PARTY. THE FOLLOWING ITEMS MUST BE CHECKED AND INITIALED TO BE INCLUDED IN THE USE AND/OR DISCLOSURE OF OTHER HEALTH INFORMATION:

_____ SUBSTANCE ABUSE (INCLUDING ALCOHOL/DRUG ABUSE) _____ MENTAL OR BEHAVIORAL HEALTH
_____ HIV RELATED INFORMATION (AIDS RELATED TESTING) _____ SEXUALLY TRANSMITTED DISEASES

_____ _____
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE DATE

5

PURPOSE OF DISCLOSURE: FOR PURPOSES OF VERIFICATION OF THE UNDERSIGNED'S COMPLIANCE WITH THE MEDICAID CONSUMER DIRECTED SERVICES PROGRAM.

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ACKNOWLEDGEMENTS (INITIAL EACH LINE):

_____ I UNDERSTAND THIS AUTHORIZATION WILL EXPIRE ONE YEAR AFTER THE DATE I EXECUTE THIS AUTHORIZATION.
_____ I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY NOTIFYING THE PROVIDING ORGANIZATION IN WRITING, AND IT WILL BE EFFECTIVE ON THE DATE NOTIFIED, EXCEPT TO THE EXTENT RECORDS HAVE ALREADY BEEN RELEASED.
_____ I UNDERSTAND THAT INFORMATION USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE SUBJECT TO REDISCLOSURE BY THE RECIPIENT AND NO LONGER PROTECTED BY FEDERAL PRIVACY REGULATIONS.
_____ BY AUTHORIZING THIS USE OR DISCLOSURE OF INFORMATION, THERE WILL BE NO CONDITIONS PLACED ON MY HEALTH CARE OR PAYMENT FOR MY HEALTH CARE.
_____ I UNDERSTAND MY REQUEST WILL BE ACTED UPON WITHIN 30 DAYS. IF I AM NOT PROVIDED ACCESS OR INFORMATION CANNOT BE SUPPLIED, I UNDERSTAND I WILL BE NOTIFIED, AND HAVE THE RIGHT TO REQUEST REVIEW OF ANY DENIAL OF ACCESS OTHER THAN THOSE MADE IN ACCORDANCE WITH APPLICABLE LAW.
_____ I UNDERSTAND THAT A COPY OF THIS AUTHORIZATION SHALL HAVE THE SAME EFFECT AS THE ORIGINAL HEREOF.
_____ I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THIS AUTHORIZATION.
_____ I EXPRESSLY AUTHORIZE THE MEDICAL PROVIDER TO RELEASE THE REQUESTED INFORMATION BY MAIL TO THE PERSON/ENTITY AT THE ADDRESS LISTED IN SECTION 2, ABOVE.

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_____ _____
SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE DATE RELATIONSHIP

INSTRUCTIONS FOR COMPLETING
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

SECTION #	INSTRUCTIONS
1	Enter your personal identifying information, including your name and current address and telephone numbers. In addition, you must specify your date of birth and social security number.
2	Enter the address of the medical provider to whom this Authorization is being sent. For multiple medical providers, you must copy this Authorization, initialing and signing it where appropriate, and sending it to each medical provider. The party to whom the requested information is to be disclosed is indicated in Section 2.
3.	Verify the accuracy of the scope of information to be released as well as the time period for which the information is to be released. If you do not agree with the information to be released or the time period specified, contact your legal counsel or, if you do not have legal counsel, the attorney at whose request this Authorization has been issued at the telephone number listed in Section 2.
4.	The items contained in Section 4 must be checked and initialed in order to be included in the use and/or disclosure of other health information. Please initial these items and sign and date Section 4 where indicated.
5.	Initial the "Purpose of Disclosure" where indicated.
6.	Initial each "Acknowledgement" where indicated.
7.	Sign and date the Acknowledgement. If you are a legal representative for the patient identified in Section 1, you must sign your name and specify your relationship to the patient.
8.	Return a fully executed copy of this form to the address of the party requesting this information, listed in Section 2, for each healthcare provider that has information relevant to this request