Missouri Department of Health and Senior Services
P.O. Box 570, Jefferson City, MO 65102-0570 | Phone: 573-751-6400 | FAX: 573-751-6010
RELAY MISSOURI for Hearing and Speech Impaired and Voice dial: 711

Sarah Willson
Director

Mike Kehoe
Governor

Explanation of the Authorization for Disclosure of Medical/Health Information Form

To create the most effective Home and Community-Based Services (HCBS) plan, we need your permission to share your medical/health information with your care team. We need your signature on the enclosed form to protect your privacy under federal law (HIPAA). This helps ensure your privacy by letting you decide who can access your records, as required by the federal HIPAA law.

What the form does: Allows us to communicate with your other providers and authorized persons (e.g., doctors, specialists, family members, etc.) regarding Home and Community Based Service (HCBS) eligibility and care planning.

Why we need this form: Ensures a mutual understanding between all providers and authorized persons, avoids gaps in care, and connects you to necessary services.

What happens if you choose not to sign the form? Signing this form is completely voluntary. However, if you choose not to sign, it may limit our ability to coordinate your care and gather all the necessary information for the assessment and care planning process.

Please fill in all highlighted sections of the form and add your signature (example below):

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Save Print Reset

STATE OF MISSOURI
AUTHORIZATION FOR DISCLOSURE OF CONSUMER MEDICAL/HEALTH INFORMATION

I, ENTER NAME HERE (NAME OF CONSUMER, PARENT, GUARDIAN/LEGAL REPRESENTATIVE) authorize and request

Check all that apply:

- ☐ Department of Mental Health (DMH)
- ☒ Department of Health and Senior Services (DHSS)
- ☐ Department of Social Services (DSS)
- ☐ Department of Elementary and Secondary Education (DESE)
- ☐ any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility or other health care provider that has provided payment, treatment or services to me or on my behalf.
- ☒ Other: ENTER AUTHORIZED PERSON'S NAME HERE (NAME OF FACILITY, AGENCY, MENTAL HEALTH CENTER, PERSON)

to **disclose/release** the below specified information of:

NAME	DCN	DATE OF BIRTH	SOCIAL SECURITY NUMBER
PARTICIPANT NAME HERE	MEDICAID NUM HERE	01/01/1900	111-11-1111

WHO RECEIVED SERVICES ON (DATES)
Currently Receiving Services

To: **(check all that apply)**

- ☐ Department of Mental Health (DMH)
- ☒ Department of Health and Senior Services (DHSS)
- ☐ Department of Social Services (DSS)
- ☐ Department of Elementary and Secondary Education (DESE)
- ☒ Other: ENTER AUTHORIZED PERSON's NAME HERE (NAME OF FACILITY, AGENCY, MENTAL HEALTH CENTER, PERSON)
  ENTER ADDRESS and PHONE NUMBER (ADDRESS, CITY, STATE, ZIP)

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MY SIGNATURE BELOW ACKNOWLEDGES THAT I HAVE READ, UNDERSTAND, AND AUTHORIZE THE RELEASE OF MY PHI.

SIGNATURE OF CONSUMER	DATE
Sign Here	
WITNESS	DATE
SIGNATURE OF PARENT/LEGAL GUARDIAN/REPRESENTATIVE	

(Please include a Description of Authority to Act on Consumer's Behalf and attach a copy of the Document Granting Authority, where applicable)

Use the included self-addressed stamped envelope to return the completed form to:

This release of information is good for one year from the date you sign it. You can cancel this release at any time by providing written notice and mailing it to .

For additional questions, please feel free to call our office at

Sincerely,