HIPAA Privacy Authorization Form

Authorization for use or disclosure of protected health information.
(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

Return to: Missouri Attorney General's Office
Attn: Jodi Lehman
PO Box 899
Jefferson City, MO 65102

MISSOURI ATTORNEY GENERAL
CHRIS KOSTER

573-751-3321
ago.mo.gov

1 I hereby authorize _____ to use and/or disclose the
NAME OF HEALTH CARE PROVIDER

protected health information described below to _____ .
NAME OF INDIVIDUAL

2 Authorization for Release of Information. Covering the period of health care from

☐ _____ to _____ **OR** ☐ All past, present and future periods:

a ☐ I hereby **authorize the release of my complete health record** (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse).

OR

b ☐ I hereby **authorize the release of my complete health record with the exception of the following information**:

☐ Mental health records ☐ Communicable diseases (including HIV and AIDS)

☐ Alcohol/drug abuse treatment ☐ Other: _____

3 This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

4 This authorization shall be in force and effect until _____ ,
DATE OR EVENT
at which time this authorization expires.

5 I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

6 I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

7 I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE DATE

_____ _____
PRINT NAME OF PATIENT OR PERSONAL REPRESENTATIVE RELATIONSHIP TO PATIENT