Center for Behavioral Health
University of Missouri – St. Louis

AUTHORIZATION FOR DISCLOSURE OF CLIENT MEDICAL/HEALTH INFORMATION

I,_____, authorize and request the USML – Center for Behavioral Health (CBH), 12837 Flushing Meadows Drive, Suite 220, Town & Country, MO 63131, to release* or obtain* the below specified information of:

Client's Name	Date of Birth	Social Security Number
_____	_____	_____

Who received services from (Dates): _____

To/From _____
(Name of Person or Organization)

_____
(Telephone)

_____
(Address, City, State and Zip Code)

The specific information to be disclosed or obtained is:

Education	**Mental Health Treatment**	**Other Medical Care**
☐ All School Records	☐ Psychiatric Evaluation(s)	☐ Medical Records
☐ Teacher Rating Scales	☐ Psychological Evaluation(s)	☐ History/Physical
☐ Interview with Teacher/Staff	☐ History/Physical	☐ Consult with Physician
☐ Psychological Evaluation(s)	☐ Discharge/Treatment Summary	

☐ **Other**_____

_____

The information will be used only for the following purpose(s):

☐ Evaluation and Report
☐ Treatment Planning
☐ Legal Purposes
☐ Client's Request
☐ Other_____

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 the following:

☐ Sexually Transmitted Diseases	☐ Acquired Immunodeficiency Syndrome (AIDS)
☐ Human Immunodeficiency Virus (HIV)	☐ Other communicable diseases
☐ Alcohol or Drug Abuse	

* Delete as applicable

2. This authorization includes both information presently compiled and information to be compiled during the course of treatment at the above-named facility or agency paying for services during the specified time frame.

3. This authorization becomes effective on the date it is signed. This authorization automatically expires on the following date, event, or special condition _____

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

5. 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 at the UMSL – Center for Behavioral Health. I further understand that actions already taken based on this authorization, prior to revocation, will NOT be affected.

6. 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.**

7. 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. **In addition to elsewhere in this document, please sign below if you are authorizing the release of alcohol and drug abuse information:**

(Signature of Client or Legal Guardian)

NOTE: Prohibition of Redisclosure: Information that has been disclosed from records whose confidentiality is protected by Federal law (42 CFR 2) that prohibits 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.

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 from CBH. I understand that I may request to inspect or request a copy of information to be used or disclosed. I understand that any disclosure of information carries the potential for redisclosure by the recipient and may no longer be protected by applicable confidentiality laws. If I have questions about disclosure of my medical/health information, I can contact the Privacy Officer for CBH.

My signature below acknowledges that I have read, understand, and authorize the disclosure of my PHI.

I acknowledge and agree that this Authorization may be signed by electronic signature, which shall be considered an original signature for all legal purposes and shall have the same force and effect as an original signature.

X _____

Signature of Client or Legal Guardian **Date**

X _____

Witness's Signature **Date**

Relationship to Patient _____

NOTICE OF REVOCATION (only sign below if you are REVOKING an authorization)

I, _____, 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 disclosures by CBH based on this authorization, prior to receipt of this revocation, will not be affected.

X _____ _____

Signature of Client or Legal Guardian Date

X _____ _____

Witness's Signature Date

If you choose to revoke your authorization, please provide a copy of the completed revocation to the Privacy Officer of this agency:

a) By Mail: Attn: Privacy Officer
UMSL – Center for Behavioral Health
12837 Flushing Meadows Drive, Suite 220
St. Louis, MO 63131

b) By telephone: 314-516-4357

c) By fax: 314-516-5347