Center for
Behavioral Health
University of Missouri – St. Louis

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Town & Country, Missouri 63131
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AUTHORIZATION FOR DISCLOSURE OF CLIENT MEDICAL/HEALTH INFORMATION

I,____, authorize and request the UMSL Center for
(Name of Client, Parent, Guardian/Legal Representative)
Behavioral Health, 12837 Flushing Meadows Drive, Suite 220, Town & Country, Missouri 63131, to release* or obtain* the below specified information of:

______________________________ ____________________
Client's Name Date of Birth

Who received services from (Dates): ____

To/From ____
(Name of Person or Organization)

____
(Telephone) (Fax)

____
(Address, City, State and Zip Code)

____
(Email Address)

The specific information to be disclosed or obtained is:

Education
- ☐ All School Records
- ☐ Teacher Rating Scales
- ☐ Interview with Teacher/Staff
- ☐ Psychological Evaluation(s)

Mental Health Treatment
- ☐ Psychiatric Evaluation(s)
- ☐ Psychological Evaluation(s)
- ☐ History/Physical
- ☐ Discharge/Treatment Summary

Other Medical Care
- ☐ Medical Records
- ☐ History/Physical
- ☐ Consult with Physician

☐ **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
- ☐ Human Immunodeficiency Virus (HIV)
- ☐ Alcohol or Drug Abuse
- ☐ Acquired Immunodeficiency Syndrome (AIDS)
- ☐ Other communicable diseases

* 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 Community Psychological Service. 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 CPS. 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 CPS.

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

X_______________________________________	X_____________________________________
Signature of Client or Legal Guardian Date	Witness's Signature Date

Relationship to Patient ________________________________