Authorization for Release of Protected Health Information

Patient Identification:

Printed Name: _____ **Date of Birth**: _____

Address: _____ **SSN**: _____

_____ **Telephone**: _____

Information to be released by:

_____
(Physician or Facility)

_____
(Street Address)

_____
(City, State and Zip Code)

_____
(Telephone Number)

Information is to be sent to:

U.S. Probation Office
(Individual/Agency/Facility)

111 S. 10th Street
(Street Address)

St. Louis, MO 63102
(City, State and Zip Code)

_____
(Telephone Number)

Information To Be Released – Covering the Periods of Health Care

From (date): _____ **To (date)**: _____

Please check type of information to be released:

☐ Complete health record	☒ Diagnosis & treatment codes	☒ Discharge summary
☐ Laboratory test results	☐ Complete billing record	☐ X-ray films/images
☐ Other (Specify)		

Purpose of Request:

☐ Treatment or consultation	☐ At the request of the patient	☐ Billing or claims payment
☒ Other (Specify) Court Ordered Investigation		

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information. I agree to its release. **Check One: ☒ Yes ☐ No**

I understand if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment I agree to its release. **Check One: ☒ Yes ☐ No**

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this Authorization, you have the right to revoke this Authorization by submitting a notice in writing to the Department of HIS or other Department to whom you are authorizing disclosure. Unless revoked, this Authorization will expired on the following date or event _____, or 90 days from date of signature, unless otherwise specified.

Re-release

I understand the information released pursuant to this Authorization may be subject to re-release by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

Your provider will not deny treatment if you do not sign this form. You may inspect or copy your protected health information. By signing below, you authorize your provider, identified above, to release your protected health information specified.

Signature: _____ **Date**: _____

Authority to Sign – if not patient: _____ Witness: _____

Identity of Requestor Verified via: ☐ Photo ID ☐ Matching Signature ☐ Other, specify

ID Verified by: _____

PROB 11E
(Rev. 5/05)

UNITED STATES PROBATION SYSTEM
AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION
SUBSTANCE ABUSE AND MENTAL HEALTH TREATMENT PROGRAMS

I, _____ , the undersigned,
(Name of Client)

hereby authorize _____ to release confidential
(Name of Program)

information in its records, possession, or knowledge of whatever nature may now exist or come to exist to the United States Probation Office of the Missouri Eastern .
District Name

The confidential information to be released will include: date of entrance to program; attendance records; urine testing results; type, frequency and effectiveness of therapy (including psychotherapy notes); general adjustment to program rules; type and dosage of medication; response to treatment; test results (psychological, vocational, etc.); psychotherapy notes; date of and reason for withdrawal from program; and prognosis.

The information which I now authorize for release is to be used in connection with the preparation of a court-ordered report.

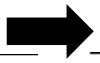
I understand that the probation office may use the information hereby obtained only in connection with its official duties, including total or partial disclosure of such, to the District Court.

I understand that this authorization is valid until I have been sentenced and my sentence is final, at which time this authorization to use or disclose this information expires. 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.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the program's privacy contact at:

_____
(Name and Address of Program)

I understand that if I revoke this authorization to release confidential information, I will thereby revoke my authorization to further disclosure of such information. I also understand that revoking this authorization before the completion of the presentence investigation will be reported to the court.



_____ _____
(Signature of Parent or Guardian if Client is a Minor) (Signature of Client)

_____ _____
(Date Signed) (Date Signed)

_____ _____
(Name & Title of Witness) (Date Signed)

PROB 48E
(Rev. 07/13)

CUSTOMER CONSENT AND AUTHORIZATION FOR ACCESS TO FINANCIAL RECORDS FOR PRESENTENCE REPORT

I, _____, having read the explanation
(Name of Customer)

of my rights, which is attached to this form, and having been convicted in the U.S. District Court, in accordance with Rule 32(d)(2)(A)(ii) (and 18 U.S.C. § 3664(d)(3) when restitution may be imposed), hereby authorize the

_____
(Name and Address of Financial Institution or Credit Agency)

to disclose the following financial records:

to _____, an officer of the
(Name of Probation Officer Allowed Access)

U.S. District Court for the Missouri Eastern ,
(Name of District Court)

to obtain information on assets I own or control, fully describing my financial resources to the United States probation officer for the purpose of preparing a presentence investigation report.

I understand that this authorization may be revoked by me in writing at any time before my records, as described above, are disclosed and that this authorization is valid for no more than three (3) months from the date of my signature. I understand further that my authorization cannot be required as a condition of my doing business with the above-named financial institution.

_____ _____
(Date) *(Signature of Customer)*

_____ _____
(Social Security Number of Customer) *(Date of Birth of Customer)*

_____
(Address of Customer)

Section 1104(a) of the Right to Financial Privacy Act, 12 U.S.C. § 3404(a).

PROB 48E
(07/13)

STATEMENT OF CUSTOMER RIGHTS UNDER THE RIGHT TO FINANCIAL PRIVACY ACT OF 1978

Federal law protects the privacy of your financial records. Before banks, savings and loan associations, credit unions, credit card issuers, or other financial institutions may give financial information about you to a federal agency, certain procedures must be followed.

Consent to Financial Records

You may be asked to consent to make your financial records available to the government. You may withhold your consent, and your consent is not required as a condition of doing business with any financial institution. If you give your consent, it can be revoked in writing at any time before your records are disclosed and, in any event, is effective for a period of not more than three months. Your financial institution must keep a record of the instances in which it discloses your financial information to the government, and this record will be available to you upon request, unless a court order restricting your right to such record has been obtained by the government.

Without Your Consent

Without your consent, a Federal agency that wants to see your financial records may do so ordinarily only by means of a lawful subpoena, summons, formal written request, or search warrant for that purpose.

Generally, the Federal agency must give you advance notice of its efforts to obtain your records by one of the above means, explaining why the information is being sought and telling you how to object in court to the release of your records.

Exceptions

If the government obtains a search warrant for your records, or if the government convinces the court that there are legitimate reasons to delay giving you notice, the Federal agency will be able to obtain your records without providing you notice beforehand.

In situations where you do not receive advance notice that the government is seeking your financial records, you will be notified once the reason for the delay of notice no longer exists.

Transfer of Information

Generally, a Federal agency which obtains your financial records is prohibited from transferring them to another Federal agency unless it certifies in writing that the transfer is proper and sends a notice to you that your records have been sent to another agency.

Penalties

If the Federal agency or financial institution violates the Right to Financial Privacy Act, you may sue for damages or to seek compliance with the law. If you win, you may be repaid your attorney's fees and costs.

PROB 11H
(Rev. 5/03)

AUTHORIZATION
TO RELEASE GOVERNMENT (STATE OR FEDERAL) INFORMATION
TO PROBATION OFFICER

I, _____, the undersigned, hereby waived my rights under the Privacy Act, 5 U.S.C. 552a (Supp. IV, 1974), and authorize the disclosure to the United States Probation Office of the Missouri Eastern District _____ or its authorized representative(s) or employee(s), any and all information pertaining to me, contained in the files or systems of records maintained by any government agency subject to the Privacy Act, which such agency sees fit to convey, either orally or in writing, to the aforementioned Probation Office.

I hereby waive any rights I may have under the Privacy Act to prior notice of such disclosure, or of any rights I may have to an accounting of such disclosure to the aforementioned Probation Office.

I understand that this authorization will be used by the aforementioned Probation Office to request disclosure of information pertaining to me from any or all federal or state agencies.

This information is to be obtained for the purpose of conducting a presentence investigation and making a report or for supervision.

Regarding protected health information, I understand that this authorization is valid until my release from supervision, at which time this authorization to use or disclose this information expires. 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.

Regarding protected health information, I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the program's privacy contact at:

_____
(Name and Address of Program)

Regarding protected health information, I understand that if I revoke this authorization to release confidential information, I will thereby revoke my authorization to further disclosure of such information. I also understand that revoking this authorization before I satisfy the condition of my supervision that requires this information will be reported to the court. My revocation of authorization under such circumstances could be considered a violation of a condition of my post-conviction supervision.

_____
Authorizing Signature (full name)

_____ _____
Full Name (printed or typed) Date

_____
Parent/Guardian Signature, if Required

_____
Attorney Signature, if Available

WITNESS —

_____ _____
Probation Officer Date

PROB 11G
(Rev. 5/03)

AUTHORIZATION TO RELEASE INFORMATION
(PRIVATE PERSON OR ORGANIZATION)
TO PROBATION OFFICER

TO WHOM IT MAY CONCERN:

I, _____, the undersigned, hereby authorize the United States Probation Office for the Missouri Eastern District or its authorized representative(s) or employee(s), bearing this release or copy thereof, to obtain any information in your files pertaining to my:

- ☒ Employment
- ☒ Education Records (including, but not limited to academic achievement, attendance, athletic, personal history, and disciplinary records)
- ☒ Medical Records
- ☒ Psychological and Psychiatric Records

I hereby direct you to release such information upon request of the bearer. This release is executed with full knowledge and understanding that the information is for the United States Probation Office's official use.

I hereby release you, as custodian of such records, any school, college, or university, or other educational institution; hospital or other repository of medical records; social service agency; any employer or retail business establishment, including its officers, employees, or related personnel, both individually and collectively, from any and all liability for damages of whatever kind which may at any time result to me, my heirs, family, or associates because of compliance with this authorization and request for information or any other attempt to comply with it.

Regarding protected health information, I understand that this authorization is valid until my release from supervision, at which time this authorization to use or disclose this information expires. 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.

Regarding protected health information, I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the program's privacy contact at:

_____
(Name and Address of Program)

Regarding protected health information, I understand that if I revoke this authorization to release confidential information, I will thereby revoke my authorization to further disclosure of such information. I also understand that revoking this authorization before I satisfy the condition of my supervision that requires me to participate in the program will be reported to the court. My revocation of authorization under such circumstances could be considered a violation of a condition of my post-conviction supervision.

➡ _____
(Authorizing Signature - Full Name)

_____ _____
(Full Name - Printed or Typed) (Date)

WITNESS — _____ _____
(Probation Officer) (Date)

Missouri Department of SOCIAL SERVICES
Your Potential. Our Support

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

I, _____ authorize and request
(NAME OF CLIENT, PARENT, GUARDIAN/LEGEAL REPRESENTNATIVE)

Check all that apply:

- ☐ Department of Social Services (DSS)
- ☒ Division of Youth Services (DYS)
- ☐ MO HealthNet Division (MHD)
- ☐ Division of Finance & Administrative Services (DFAS)
- ☐ Missouri Medicaid Audit and Compliance (MMAC)
- ☐ Family Support Division (FSD)
- ☐ Children's Division (CD)
- ☐ Division of Legal Services (DLS)
- ☐ Missouri Medicaid Audit and Compliance (MMAC)
- ☐ Other: _____
(NAME OF FACILITY, AGENCY, MENTAL HEALTH CENTER, PERSON)

to disclose/release the below specified information of:

NAME	DCN	DATE OF BIRTH	SOCIAL SECURITY NUMBER

WHO RECEIVED SERVICES FROM (DATES)

IV-D NUMBER (REQUIRED FOR REQUESTS FOR CHILD SUPPORT RECORDS)

to (check all that apply)

- ☐ Attorney: _____
- ☐ Employer: _____
- ☐ Legislator/Staff: _____
- ☐ Governor's Staff: _____
- ☒ Other: _____
(NAME OF FACILITY, AGENCY, PERSON)

_____
(ADDRESS, CITY, STATE, ZIP)

THE PURPOSE OF THIS DISCLOSURE IS (CHECK ALL THAT APPLY)

- ☐ Eligibility Determination
- ☐ Legal Consultation/Representation
- ☐ Legal Proceedings
- ☐ Employment
- ☐ Complaint/Investigation/Resolution
- ☐ Treatment Planning
- ☐ Continuity of Services/Care
- ☐ Background Investigation
- ☐ At Consumer's Request
- ☐ To share or refer my information to other Missouri state agencies (such as DMH, DHSS, DSS, DESE, etc.) to obtain services consistent with the _____ program (please complete the name of the program in which you want to participate)
- ☒ Other (specify) Court Ordered Investigation

THE SPECIFIC INFORMATION TO BE DISCLOSED IS (CHECK ALL THAT APPLY)

- ☒ Entire File
- ☐ Hotline Investigations
- ☐ Eligibility Determinations
- ☐ Licensure Information
- ☐ Home Studies
- ☐ Substance Abuse Treatment
- ☐ Medical/Psychiatric Evaluation/Treatment Records
- ☐ Client Employment Records
(NOTE: THIS DOES NOT INCLUDE THE RELEASE OF EMPLOYMENT RECORDS FOR DSS EMPLOYEES)
- ☐ Benefits Received
- ☐ Completed Fraud Investigations
- ☐ Other _____

Note: Information pertaining to third parties in your records may be redacted or withheld entirely unless those persons authorize the department, in writing, to release their information to you. Other information may be redacted when required by law.
Note: Requests for DSS records may be subject to the collection of reasonable fees prior to the release of records.

1. **READ CAREFULLY**: I understand that my information and records with the Department of Social Services are confidential by law. I understand that by signing this authorization, I am allowing the release of any and all of my information and records which I am authorized to receive as specified on this document whether past, present or created in the future up to the expiration or revocation date of this authorization, unless otherwise authorized. The protected information in my records may include medical treatment and/or evaluation information, mental/behavioral health information, information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), other communicable or environmental diseases and conditions, alcohol/drug abuse, application for and/or receipt of public assistance benefits, alcohol/drug abuse information, and/or information concerning child abuse and neglect.
2. This authorization includes both information presently compiled and information to be compiled during your association or dealings with the Department of Social Services, during the specified time frame.
3. Unless otherwise indicated, this authorization becomes effective on the date of signature below and will expire one year from that date. If you would like to specify a different expiration date, please indicate that date here: ——————————————————
4. 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 of the Department of Social Services at 221 W. High Street, Room 230, Jefferson City, MO 65102. I further understand that actions already taken based on this authorization, prior to revocation, will **NOT** be affected.
5. I understand that I have the right to receive a copy of this authorization upon request. **A photographic copy of this authorization is as valid as the original.**
6. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to receive services from the Department of Social Services. I understand that I may request to inspect or request a copy of information to be used or disclosed, as provided in 45 CFR Sections 155.260 and 164.524. I understand that any disclosure of information carries with it the potential for redisclosure by the party receiving it and that the information may no longer be protected by law once it is in the possession of the receiving party. If I have questions about disclosure of my information, I can contact the Privacy Officer of the Department of Social Services, my caseworker or family support eligibility specialist.

My signature below acknowledges that I have read and understood the text above, and authorize the release of my confidential information.

SIGNATURE OF CLIENT	DATE
SIGNATURE OF PARENT/LEGAL GUARDIAN/REPRESENTATIVE (IF APPLICABLE)	

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

AUTHORIZATION TO DISCLOSE SUBSTANCE ABUSE TREATMENT INFORMATION

Alcohol and drug abuse treatment records are specifically protected by federal regulations (42 CFR Part 2) and by signing in the block below, I am allowing the release of any alcohol and/or drug information or records (if any) that I may have to the agency or person specified on this form. Prohibition of Redisclosure: Federal regulations (42 CFR Part 2) prohibit the recipient of substance abuse treatment records from making further disclosure of those records without the specific written authorization of the person to whom those records pertain, or as otherwise specified by such regulation. A general authorization for disclosure of medical or other information is NOT sufficient for this purpose. **Sign below if you wish to authorize the release of alcohol and drug abuse information.**

SIGNATURE OF CLIENT/ PARENT/LEGAL GUARDIAN/REPRESENTATIVE (IF APPLICABLE)	DATE

NOTICE OF REVOCATION

EFFECTIVE DATE

I, _____, (Client) 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 actions based on this authorization, prior to revocation, will not be affected.

SIGNATURE OF CLIENT	DATE
SIGNATURE OF PARENT/LEGAL GUARDIAN/REPRESENTATIVE (IF APPLICABLE)	DATE

If you choose to revoke your authorization, please provide a copy of the completed revocation to the Privacy Officer of the Department of Social Services at 221 W. High Street, Room 230, Jefferson City, MO 65102.