

MBCH Children and Family Ministries
AUTHORIZATION FOR DISCLOSURE OF INFORMATION

CONSUMER _____ DATE OF BIRTH _____ SS# _____

I, the undersigned, hereby give my permission to _____ (staff member) of MBCH Children and Family Ministries to obtain and/or release necessary information regarding the above person from/to:

Name of person/agency

Address of person/agency

DISCLOSURE SHALL BE LIMITED TO THE FOLLOWING SPECIFIC INFORMATION:
(check the specific information requested)

- | | |
|---|--|
| <input type="checkbox"/> DISCHARGE SUMMARY | <input type="checkbox"/> PSYCHIATRIC HISTORY & MENTAL STATUS |
| <input type="checkbox"/> MEDICAL HISTORY & PHYSICAL EXAM | <input type="checkbox"/> RESULTS OF PSYCHOLOGICAL TESTS |
| <input type="checkbox"/> LAB & X-RAY REPORTS | <input type="checkbox"/> EDUCATIONAL ASSESSMENT AND REPORTS |
| <input type="checkbox"/> COPY OF COMPLETE SCHOOL TRANSCRIPTS | <input type="checkbox"/> PSYCHOSOCIAL ASSESSMENTS |
| <input type="checkbox"/> COPY OF SCHOOL HEALTH RECORDS | <input type="checkbox"/> COPY OF SCHOOL BEHAVIORAL SUMMARIES |
| <input type="checkbox"/> DRUG/ALCOHOL RECORDS | <input type="checkbox"/> ADOPTION HOME STUDY/ASSESSMENT |
| <input type="checkbox"/> EMPLOYMENT HISTORY | <input type="checkbox"/> OTHER (SPECIFY): _____ |
| <input type="checkbox"/> HISTORY OF KNOWN COMMUNICABLE DISEASE(S) INCLUDING HIV POSITIVE/AIDS | |
| <input type="checkbox"/> TREATMENT PLAN(S) | |

The purpose for the disclosure is: _____

I understand that the information above that is disclosed to MBCH Children and Family Ministries will be shared with other staff members of MBCH Children and Family Ministries for the purpose of assessment, service planning, and case supervision.

Your Rights with Respect to this Authorization:

Right to Inspect or Copy the Health Information to be Used or Disclosed – I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information. **Right to Receive a Copy of This Authorization:** I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. **Right to Refuse to Sign this Authorization** -I understand that I am under no obligation to sign this form and that the person(s) and /or organization(s) listed above who I am authorizing to use and /or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. I understand that there is a potential for the information to be redisclosed by the recipient. **Right to Withdraw This Authorization:** I understand that I may revoke this authorization in writing to the MBCH Children and Family Ministries Privacy Officer. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization. **Notice of Privacy Practices** - I understand that I may request a copy of the MBCH Children and Family Ministries Notice of Privacy Practices in writing to the MBCH Children and Family Ministries Privacy Officer.
For information regarding any of the above, you may contact the MBCH Children and Family Ministries Privacy Officer at 11300 St. Charles Rock Road, Bridgeton, Missouri 63044.

This authorization expires _____ (not to exceed 90 days for one time release or 1 year for ongoing cooperative service provider).

Dated: _____

SIGNATURE OF PARENT/GUARDIAN/AUTHORIZED REPRESENTATIVE OF PATIENT (Indicate Which)

Dated: _____

WITNESS

Please send information to: _____

_____, or

Fax to: _____