MISSOURI DEPARTMENT OF SOCIAL SERVICES

AUTHORIZATION FOR RELEASE OF MEDICAL/HEALTH INFORMATION

I, _____ do hereby authorize and request
(NAME OF INDIVIDUAL, GUARDIAN, LEGAL OR PERSONAL REPRESENTATIVE)

that Academie LaFayette release or disclose to
(NAME OF ENTITY, AGENCY OR INDIVIDUAL HOLDING THE RECORDS)

Upper Room KC the health information specified
(NAME OF ENTITY, AGENCY, INDIVIDUAL OR CLASS INTENDED TO RECEIVE THE INFORMATION)

below that relates to the following individual:

NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER

ADDRESS, CITY, STATE	OTHER ID

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

- ☐ Entire Record
- ☐ Treatment or Tests
- ☐ Laboratory Reports
- ☐ Psychological Evaluation
- ☐ Medical History, Examination, Diagnosis
- ☐ Hospital Records Including Reports
- ☒ Immunizations/Allergy Records
- ☐ Mental Health Records/Reports
- ☐ Prescriptions
- ☐ X-ray Reports
- ☐ Healthcare Payments
- ☐ Other (Specify): _____

INCLUDE INFORMATION WITHIN THE FOLLOWING DATE(S)

EXPIRATION DATE

This authorization is good until the date(s) _____ , or for one year.

PURPOSE OF REQUEST FOR DISCLOSURE

- ☐ At the request of the individual or the individual's legal representative
- ☐ Other (Specify): _____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

You can not be required to sign this disclosure authorization form nor may treatment or payment be refused if you do not sign, but if you sign this form you must be given a copy. You have the right to inspect the information to be disclosed and you may revoke this authorization by writing the DSS Privacy Officer at PO Box 1527, Jefferson City, MO 65102. A revocation of this authorization will not reverse disclosures already made under this authorization and when a disclosure occurs, there is a possibility the information might be re-disclosed by the recipient. For more information you may call 573-751-1334. (TDD 800-735-2966 or 800-735-2466 - Voice access to Relay Missouri).

SIGNATURE

I have had an opportunity to review and understand the content of this authorization form, and by signing this authorization, I confirm it accurately reflects my wishes. If a guardian, legal representative or a personal representative signs this document they must provide separate documentation of their status and authority.

SIGNED (INDIVIDUAL, GUARDIAN, LEGAL OR PERSONAL REPRESENTATIVE	DATE

ADDRESS