

# AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

(See Notes on back for how to complete this form)

I \_\_\_\_\_ (individual name) hereby authorize the use or disclosure of my health information as described in this authorization.

1. \_\_\_\_\_ is hereby authorized to provide the information;
2. \_\_\_\_\_ is hereby authorized to receive and use the information;
3. The information to be released herein is as follows:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
4. The purpose of this request is the following:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. I understand that I have the right to revoke this authorization at any time by notifying The Curators of the University of Missouri in writing directed to: Suzanne Hart, Manager Faculty and Staff Benefits and Plan HIPAA Privacy Official, 114 Heinkel Bldg., Columbia, MO 65211. I understand that the revocation is only effective after it is received by The Curators of the University of Missouri. I understand that any use or disclosure of the information under this authorization made prior to the effective date of the revocation will not be affected by the revocation.
6. I understand that after this information is disclosed, state or federal law might not protect it and the recipient might re-disclose it.
7. The following is conditioned upon your providing this authorization:  
\_\_\_\_\_
8. I understand that I am entitled to receive a copy of this authorization.
9. I understand that this authorization will expire: \_\_\_\_\_
10. I agree and understand that a photocopy or facsimile copy of this authorization will be as valid as the original.

Signature of Individual: \_\_\_\_\_ (Name) \_\_\_\_\_ (Date)

**(Notarization Required – See Back)**

Subscribed and sworn to before me this \_\_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
Notary Public

My Commission Expires:  
\_\_\_\_\_

(If a personal representative of the individual executes this form, that representative warrants that he/she has authority to sign this form on the basis of the following: \_\_\_\_\_.)  
\_\_\_\_\_.)

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### Notes for Use of HIPAA Authorization

**Item No.**

1. The specific person/ organization or class of persons authorized to provide the information should be clearly identified.
2. The specific person/ organization or class of persons authorized to receive and use the information should be identified.
3. A specific and meaningful description of the information to be released should be provided. For example, medical examination report and conclusions related to a fitness-for-work exam, or results of drug testing for employment related purposes.
4. The purpose of the request should be stated. If you do not wish to state the purpose, can simply state "At the request of \_\_\_\_\_(name of individual.)"
5. This explains to individual that he/she has a right to revoke the authorization, but any revocation must be in writing and will not be effective until after it is received by the University. Further, any use or disclosure of the information prior to the effective date of the revocation will not be affected by the revocation.
6. This informs the individual that once the requested information has been disclosed by the University as requested in the authorization, the recipient of the information may no longer protect the information from re-disclosure.
7. This states the consequences of refusing to sign the authorization. This paragraph may need to be altered to fit the purpose of the request. If there is no consequence of refusing to sign the authorization, put "None".
8. This informs the individual that he/ she has a right to a copy of the signed authorization.
9. This sets forth an expiration date for the authorization. Expiration could be on an exact date, or on the happening of an event (ie. Termination of employment.)

**Form must be signed, dated and notarized**