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Missouri Consolidated Health Care Plan
573-751-0771 · 800-487-0771 · www.mchcp.org
832 Weathered Rock Court, Jefferson City, MO 65101

Authorization to Release Protected Health Information

Public Entity Members *Please print clearly*

Submit this form:
Online: Upload through myMCHCP
Fax: 800-834-5181
Mail: PO Box 104355
Jefferson City, MO 65110-4355

MCHCP Use Only
PE ARI

Instructions

If you need assistance in completing this form, please contact MCHCP at 800-487-0771. Please fill out this form completely to ensure your authorization is valid.

Section 1 – Member Information

Member Name (Person wanting to release information):

_____

Address:

_____

City: **State**: **ZIP Code**:

_____ _____ ___ ___ ___ ___ ___

Primary Phone Number: ☐ Home ☐ Work ☐ Cell

(___ ___ ___) ___ ___ ___ – ___ ___ ___ ___

Secondary Phone Number: ☐ Home ☐ Work ☐ Cell

(___ ___ ___) ___ ___ ___ – ___ ___ ___ ___

MCHCPid (Provide **either** MCHCPid or Social Security Number)

___ ___ ___ ___ ___ – ___ ___ ___ ___ ___

or **Social Security Number**:

___ ___ ___ – ___ ___ – ___ ___ ___ ___

Section 2 – Information Disclosure

I authorize the MCHCP to use and/or disclose my protected health information to the person(s) designated below:

Name (Last, First, Middle Initial)	**Complete Address** (Street, City, State and ZIP Code)	**Relationship to Member**

Section 3 – Information Usage

I authorize release of my health record from (select one):

☐ ___ ___ / ___ ___ / ___ ___ ___ ___ to ___ ___ / ___ ___ / ___ ___ ___ ___ (MM/DD/YYYY)

☐ All past, present and future periods

EXPIRATION DATE: This authorization is valid (select one):

☐ Until ___ ___ / ___ ___ / ___ ___ ___ ___ (MM/DD/YYYY)

☐ As long as I am a member of MCHCP

☐ Until a specific event: _____

If no expiration time period is given, the authorization is valid for one year.

Section 4 – Specific Information to be Disclosed

I authorize the release of:

☐ My complete health record (INCLUDING records relating to mental health care, communicable diseases including HIV or AIDS, and alcohol/drug abuse treatment)

OR (select all that apply):

☐ My complete health record (EXCEPT records relating to mental health care, communicable diseases including HIV or AIDS, and alcohol/drug abuse treatment)

☐ Mental health records

☐ Communicable diseases, including HIV and AIDS

☐ Alcohol/drug abuse treatment

☐ Other (please specify): _____

Section 5 – Purpose of Disclosure Request

The health record is to be disclosed for the following purpose (please select one):

☐ At my request or the request of my legal representative

☐ Other (specify): _____

Section 6 – Member Authorization

I have had an opportunity to review and understand the content of this authorization form. By completing this form, I understand that I am allowing MCHCP to share my protected health information with the person(s) named above. I understand that I have the right to revoke this authorization at any time provided that I do so in writing, except to the extent that MCHCP has already used or disclosed my information based on this authorization as described in MCHCP's Notice of Privacy Practices. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be redisclosed by the recipient and may no longer be protected by federal or state law. **Note: If a guardian, legal representative or a personal representative signs this document s/he must provide separate documentation of his/her authority to act for the individual.**

Signature of Member:

_____

Date (MM/DD/YYYY):

___ ___ / ___ ___ / ___ ___ ___ ___

Or, Signature of Person Authorized by Law to Act for the Member (Attach proof of authority to act):

_____

Date (MM/DD/YYYY):

___ ___ / ___ ___ / ___ ___ ___ ___