Missouri Consolidated Health Care Plan

Authorization to Release Protected Health Information

State Members

Submit this form
Online: Upload through myMCHCP
Fax: 866-346-8785
Mail: PO Box 104355
Jefferson City, MO 65110-4355

ST ARI

Revised 10/2020

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

Name (Last, First, MI): ☐ New Name

Address: ☐ New Address

City: **State:** **Zip Code:**

MCHCP ID:

OR

Social Security Number:

Primary Phone: ☐ Home ☐ Work ☐ Cell

Secondary Phone: ☐ Home ☐ Work ☐ Cell

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, & Zip Code):	**Relationship to Member:**

Section 3: Information Usage

I authorize the 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: Subscriber 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): ___/___/___