STATE OF MISSOURI
DEPARTMENT OF SOCIAL SERVICES

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AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

I, _____ authorize and request
(NAME OF CLIENT, PARENT, GUARDIAN/LEGAL REPRESENTATIVE)

Check all that apply:

- ☐ Department of Social Services (DSS)
- ☐ Family Support Division (FSD)
- ☐ Division of Youth Services (DYS)
- ☐ Children's Division (CD)
- ☐ MO HealthNet Division (MHD)
- ☐ Division of Legal Services (DLS)
- ☐ Division of Finance & Administrative Services (DFAS)
- ☐ Missouri Medicaid Audit and Compliance (MMAC)
- ☐ Other _____
(NAME OF FACILITY, AGENCY, MENTAL HEALTH CENTER, PERSON)

to **disclose/release** the below specified information of:

NAME	DCN	DATE OF BIRTH	SOCIAL SECURITY NUMBER

WHO RECEIVED SERVICES FROM (DATES)

IV-D NUMBER (REQUIRED FOR REQUESTS FOR CHILD SUPPORT RECORDS)

to **(check all that apply)**

- ☐ Attorney: _____
- ☐ Employer: _____
- ☐ Legislator/Staff: _____
- ☐ Governor's Staff: _____
- ☐ Other _____
(NAME OF FACILITY, AGENCY, PERSON)

_____
(ADDRESS, CITY, STATE, ZIP)

THE PURPOSE OF THIS DISCLOSURE IS (CHECK ALL THAT APPLY)

- ☐ Eligibility Determination
- ☐ Legal Consultation/Representation
- ☐ Legal Proceedings
- ☐ Employment
- ☐ Complaint/Investigation/Resolution
- ☐ Treatment Planning
- ☐ Continuity of Services/Care
- ☐ Background Investigation
- ☐ At Consumer's Request
- ☐ To share or refer my information to other Missouri state agencies (such as DMH, DHSS, DSS, DESE, etc.) to obtain services consistent with the _____ program (please complete the name of the program in which you want to participate)
- ☐ Other (specify) _____

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

- ☐ Entire File
- ☐ Hotline Investigations
- ☐ Eligibility Determinations
- ☐ Licensure Information
- ☐ Home Studies
- ☐ Substance Abuse Treatment
- ☐ Medical/Psychiatric Evaluation/Treatment Records
- ☐ Client Employment Records
(NOTE: THIS DOES NOT INCLUDE THE RELEASE OF EMPLOYMENT RECORDS FOR DSS EMPLOYEES)
- ☐ Benefits Received
- ☐ Completed Fraud Investigations
- ☐ Other _____

Note: Information pertaining to third parties in your records may be redacted or withheld entirely unless those persons authorize the department, in writing, to release their information to you. Other information may be redacted when required by law.
Note: Requests for DSS records may be subject to the collection of reasonable fees prior to the release of records.

1. **READ CAREFULLY:** I understand that my information and records with the Department of Social Services are confidential by law. I understand that by signing this authorization, I am allowing the release of any and all of my information and records which I am authorized to receive as specified on this document whether past, present or created in the future up to the expiration or revocation date of this authorization, unless otherwise authorized. The protected information in my records may include medical treatment and/or evaluation information, mental/behavioral health information, information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), other communicable or environmental diseases and conditions, alcohol/drug abuse, application for and/or receipt of public assistance benefits, alcohol/drug abuse information, and/or information concerning child abuse and neglect.
2. This authorization includes both information presently compiled and information to be compiled during your association or dealings with the Department of Social Services, during the specified time frame.
3. Unless otherwise indicated, this authorization becomes effective on the date of signature below and will expire one year from that date. If you would like to specify a different expiration date, please indicate that date here: _____
4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so **IN WRITING** and present my written revocation to the Privacy Officer of the Department of Social Services at 221 W. High Street, Room 230, Jefferson City, MO 65102. I further understand that actions already taken based on this authorization, prior to revocation, will **NOT** be affected.
5. I understand that I have the right to receive a copy of this authorization upon request. **A photographic copy of this authorization is as valid as the original.**
6. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to receive services from the Department of Social Services. I understand that I may request to inspect or request a copy of information to be used or disclosed, as provided in 45 CFR Sections 155.260 and 164.524. I understand that any disclosure of information carries with it the potential for redisclosure by the party receiving it and that the information may no longer be protected by law once it is in the possession of the receiving party. If I have questions about disclosure of my information, I can contact the Privacy Officer of the Department of Social Services, my caseworker or family support eligibility specialist.

My signature below acknowledges that I have read and understood the text above, and authorize the release of my confidential information.

SIGNATURE OF CLIENT	DATE
SIGNATURE OF PARENT/LEGAL GUARDIAN/REPRESENTATIVE (IF APPLICABLE)	

(Please include a Description of Authority to Act on Client's Behalf and attach a copy of the Document Granting Authority, where applicable.)

AUTHORIZATION TO DISCLOSE SUBSTANCE ABUSE TREATMENT INFORMATION

Alcohol and drug abuse treatment records are specifically protected by federal regulations (42 CFR Part 2) and by signing in the block below, I am allowing the release of any alcohol and/or drug information or records (if any) that I may have to the agency or person specified on this form. Prohibition of Redisclosure: Federal regulations (42 CFR Part 2) prohibit the recipient of substance abuse treatment records from making further disclosure of those records without the specific written authorization of the person to whom those records pertain, or as otherwise specified by such regulation. A general authorization for disclosure of medical or other information is NOT sufficient for this purpose. **Sign below if you wish to authorize the release of alcohol and drug abuse information.**

SIGNATURE OF CLIENT/PARENT OR LEGAL GUARDIAN (IF APPLICABLE)	DATE

NOTICE OF REVOCATION

EFFECTIVE DATE

I, _____ , (Client) hereby revoke my authorization of this disclosure of information to the Agency/person listed above. This revocation effectively makes null and void any permission for disclosure of information expressly given by the above authorization. I understand that any actions based on this authorization, prior to revocation, will not be affected.

SIGNATURE OF CLIENT	DATE
SIGNATURE OF PARENT/LEGAL GUARDIAN/REPRESENTATIVE (IF APPLICABLE)	DATE

If you choose to revoke your authorization, please provide a copy of the completed revocation to the Privacy Officer of the Department of Social Services at 221 W. High Street, Room 230, Jefferson City, MO 65102.