



## Missouri Department of Elementary and Secondary Education

— Making a positive difference through education and service —

### Memo

To: Regional Managers, Supervisors, Assistant Supervisors, Sr. Secretaries, Tech Liaisons  
From: Clarinda Unger, Coordinator, Client Services  
Date: March 12, 2003  
Re: New format for requesting confidential medical information

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Effective April 1, 2003, both the 'Consent for Release of Confidential Information MO 500- 0539 (5-96)' and 'Consent for Release of Confidential Vocational Rehabilitation Information MO 500-1715 (4-91)' printed forms on hand, those available as a MS Word File, and in MoRIS, will be replaced by 'Authorization for Disclosure of Consumer Medical/Health Information MO 650-2616 (1-03)'. This effort is intended to streamline the process of disclosing information between multiple state departments including Mental Health (DMH), Health and Senior Services (DHSS), Social Services (DSS), Elementary & Secondary Education (DESE) as well as other private & public agencies and providers in Missouri. It also utilizes 'information disclosure' language which DMH, DHSS, DSS, and all medical, psychiatric, psychological, and alcohol & drug treatment providers will require for the disclosure of information on 4/14/2003 and thereafter.

The new 'Authorization for Disclosure' form is in the process of being integrated into MoRIS. You will be notified of the date it will be available. Until the new form can be accessed in MoRIS, the 'Adobe Document' file accompanying this memo contains this new document. Please detach this file to a file on your computer hard drive and open it using Adobe Acrobat Reader. Please create the initial number of forms appropriate for the district office on your copy machine. Due to the legal requirements and formatting, this new form is two pages in length. Please ensure that any forms you produce are duplex (copied on the front and back of the same sheet of paper). Please note that MO 650-2616 (1-03) will not be available as an MS Word File.

In previous memos, instructions have been provided to download and install 'Adobe Acrobat Reader' to use this type of file attachment. If you still need to install this program, please use the following link and follow the instructions provided for the installation: <http://www.adobe.com/products/acrobat/readstep2.html> . If you have further questions, your tech liaison should be able to assist you.

**Instructions for requesting confidential information, medical or otherwise, from another agency or private provider on MO 650-2616 (1-03):**

1. Insert the **printed name** of the client or authorizing parent/guardian. This will be the same person signing the 'authorization for disclosure' in step #9.
2. Use the specific 'Department' check box to identify the state entity which will **release** or **provide** the consumer medical/health or otherwise confidential information. It is the intent of this new format for more than one state department to be endorsed on a single form to streamline the process. Use the 'Other' check box and print the appropriate identifying information in the space provided for all other entities/providers not listed previously who will receive this authorization.
3. Insert the printed name, date of birth, social security number of the client/consumer for which the information will be released or provided. Approximate dates of services the releasing party provided services should be inserted. If consumer is still receiving services, you may use the date the form is completed as the end date.
4. Use the specific 'Department' check box for the state entity that will be **receiving** the medical/health information. In this case, check 'Department of Elementary and Secondary Education (DESE). Then check 'Other' and complete the pertinent information. i.e. 'DESE – Div Voc Rehab, XXXXX Senior Counselor; 1500 Southridge Dr.; Jefferson City, MO 65109 (573) 751-2343'
5. This section lists the purpose of the disclosure. Check all which apply, however it is anticipated that 'Eligibility' and 'Assessment' will always be used by DVR. In the event the client/consumer is being served by a comprehensive system of care or group of providers such as Supported Employment, TBI Case Management, TANF etc, a check box 'To share or refer....' is provided. Please print the name of the program.
6. Use the check boxes to identify the information to be disclosed and or use 'Other' and print the description of the information being requested.

(Page 2 of Form)

7. Completion of this section allows for the direct disclosure of records containing Alcohol and Drug information in accordance with 42 CFR section 2. This section must be **signed by all clients/consumers or guardians** if there is any reference to Alcohol and Drug information contained in the records you are requesting. This would even include those records in which a client is merely questioned about their Alcohol or Drug use to rule out a diagnosis. It is recommended that you have all clients review this section and gain their signature. However, it is recognized there might be occasion it might not be used due to a consumer's objection, etc.
8. This first space is the effective date of the 'Authorization for Disclosure'. It is the date the release is signed by the client/consumer or guardian and no earlier. The second space provides for the date or condition the release will expire such as 'Closure of Case with DESE – Div of Voc Rehab'
9. Signatures with date completed will be provided in this location. If the client/consumer is of legal age and their own guardian, they should endorse this form and their name should have been included in section #1. In the event the client/consumer has a legal guardian, the guardian's name should be listed in section #1 and signature with date listed here. The witnessing party signature with date, ie counselor, etc. will be required as well.
10. Only in the event a client/consumer or their guardian wishes to revoke this 'Authorization for Disclosure', please complete this section. Insert date, client (or guardian if applicable) printed name, with appropriate signatures.

VR Requesting Information from other Dept. or agency.



STATE OF MISSOURI  
AUTHORIZATION FOR DISCLOSURE OF CONSUMER MEDICAL/HEALTH INFORMATION

I, Fred J. Smith 1 authorize and request  
(NAME OF CONSUMER, PARENT, GUARDIAN/LEGAL REPRESENTATIVE)

Check all that apply:

- 2  Department of Mental Health (DMH)  Department of Health and Senior Services (DHSS)
- Department of Social Services (DSS)  Department of Elementary and Secondary Education (DESE)
- Other University Hospital & Clinics; 1 Hospital Dr. Columbia, MO 65211  
(NAME OF FACILITY, AGENCY, MENTAL HEALTH CENTER, PERSON)

to disclose/release the below specified information of:

NAME <u>Fred J. Smith</u>	DATE OF BIRTH <u>12-1-1958</u>	SOCIAL SECURITY NUMBER <u>XXX-XX-XXXX</u>
WHO RECEIVED SERVICES FROM (DATES) <u>10-13-1999 to 12-15-1999 (dates are approximate)</u>		

to (check all that apply)

- Department of Mental Health (DMH)  Department of Health and Senior Services (DHSS)
- Department of Social Services (DSS)  Department of Elementary and Secondary Education (DESE)
- Other DESE-DVR, George Q Professional - Senior Counselor  
1500A. Southridge Dr.; Jefferson City, MO 65109 (573) 757-2343  
(NAME OF FACILITY, AGENCY, MENTAL HEALTH CENTER, PERSON)  
(ADDRESS, CITY, STATE, ZIP)

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

- Eligibility Determination  Assessment  Aftercare
- Placement  Transfer/Treatment  Treatment Planning 5
- Continuity of Services/Care  Conditional/Unconditional Release Hearing  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)

- Discharge Summary  Progress Notes  Treatment Plan and/or Review
- Social Service Assessment  Educational testing, IEP, transcript, and/or grading reports
- Medical/Psychiatric Assessment(s)
- Psychometric testing, including intelligence quotient (IQ) results, neurological testing, or other developmental test results.
- Other Medical Records - Admission Summary

- 1. READ CAREFULLY:** I understand that my medical/health information records are confidential. I understand that by signing this authorization, I am allowing the release of my medical/health information. The protected health information (PHI) in my medical record includes mental/behavioral health information. In addition, it may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), other communicable diseases, and/or alcohol/drug abuse.
- Alcohol and drug abuse information records are specifically protected by federal regulations (42 CFR 2) and by signing this authorization without restrictions I am allowing the release of any alcohol and/or drug information records (if any) to the agency or person specified above. Please sign if you are authorizing the release of alcohol and drug abuse information:

*'All Clients Sign here'*

7

- This authorization includes both information presently compiled and information to be compiled during the course of treatment at the above-named facility or agency paying for services, during the specified time frame.
- This authorization becomes effective on 1-31-2003. This authorization automatically expires on the following date, event or special condition Closure of case with DVR
- If I fail to specify an expiration date, this authorization will expire in one year.
- 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 health information management department (medical records) or client information center at this facility. I further understand that actions already taken based on this authorization, prior to revocation, will **NOT** be affected.
- I understand that I have the right to receive a copy of this authorization. **A photographic copy of this authorization is as valid as the original.**
- I understand that authorizing the disclosure of this medical/health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may request to inspect or request a copy of information to be used or disclosed, as provided in 45 CFR Section 164.524. I understand that any disclosure of information carries with the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my medical/health information, I can contact the health information management director (medical records director) or client information center, or designee, or the Privacy Officer for this covered entity.

8

**THE FOLLOWING APPLIES TO ALCOHOL AND/OR DRUG ABUSE TREATMENT INFORMATION RECORDS:** Prohibition of Redisclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibit you from making further disclosure of it without the specific written authorization of the person to whom it pertains, or as otherwise specified by such regulations. A general authorization for disclosure of medical or other information is NOT sufficient for this purpose.

My signature below acknowledges that I have read, understand, and authorize the release of my PHI.

SIGNATURE OF CONSUMER <i>Client/Consumer Signature</i>	DATE <i>Date</i>
WITNESS <i>Counselor or other Witness Signature</i>	DATE <i>Date</i>
SIGNATURE OF PARENT/LEGAL GUARDIAN/REPRESENTATIVE <i>Parent/Legal Guardian Signature if Applicable</i>	

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

**NOTICE OF REVOCATION**

DATE  
*Date of Revocation*

I, *Print client name here*, (Consumer) 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 CONSUMER <i>Client/Consumer Signature</i>	DATE <i>Date</i>
WITNESS <i>Counselor or other Witness Signature</i>	DATE <i>Date</i>
SIGNATURE OF PARENT/LEGAL GUARDIAN/REPRESENTATIVE <i>Parent/Legal Guardian Signature if Applicable</i>	

10

If you choose to revoke your authorization, please provide a copy of the completed revocation to the health information management director (medical records director), or the client information center, or to the Privacy Officer of this facility.

**Instructions for VR Releasing confidential information, medical or otherwise, to an agency or private provider on MO 650-2616 (1-03):**

- A. Insert the **printed name** of the client or authorizing parent/guardian. This will be the same person signing the 'authorization for disclosure' in step #9.
- B. Use the 'Department of Elementary and Secondary Education (DESE) check box to identify who will **release** or **provide** the consumer medical/health or otherwise confidential information. Then check 'Other' and complete the pertinent information. i.e. 'DESE – Div Voc Rehab, XXXXX Senior Counselor; 1500 Southridge Dr.; Jefferson City, MO 65109 (573) 751-2343'.
- C. Insert the printed name, date of birth, social security number of the client/consumer for which the information will be released or provided. Insert the dates the client was served.
- D. Use the specific 'Department' check box for the state entity that will be **receiving** the medical/health information and print their specific address in the other section. If this does not apply, use the 'other' check box and print the appropriate information i.e. name, address, etc of where it is to be released.
- E. This section lists the purpose of the disclosure. Check any which apply. In the event the client/consumer is being served by a comprehensive system of care or group of providers such as Supported Employment, TBI Case Management, TANF, One Stop etc, a check box 'To share or refer....' is provided. Please print the name of the program.
- F. Use the check boxes to identify the information to be disclosed and or use 'Other' and print the description of the information being requested.

(Page 2 of Form)

- G. This section involves the direct disclosure of records containing Alcohol and Drug information in accordance with 42 CFR section 2. This section must be **signed by all clients/consumers or guardians** in order to release information held by the Missouri Division of Vocational Rehabilitation. Please note that internal VR records such as the Health Assessment Questionnaire, the initial interview as well as purchased Comprehensive Psychological & Neuropsychological Evaluations, and numerous medical records do contain reference to this protected Alcohol and Drug information.
- H. This first space is the effective date of the 'Authorization for Disclosure'. It is the date the release is signed by the client/consumer or guardian and no earlier. The second space provides for the date or condition the release will expire.
- I. Signatures with date completed will be provided in this location. If the client/consumer is of legal age and their own guardian, they should endorse this form and their name should have been included in section #1. In the event the client/consumer has a legal guardian, the guardian's name should be listed in section #1 and signature with date listed here. The witnessing party signature with date, ie counselor, etc. will be required as well.
- J. Only in the event a client/consumer or their guardian wishes to revoke this 'Authorization for Disclosure', please complete this section. Insert date, client (or guardian if applicable) printed name, with appropriate signatures.

VR

Releasing Information to other Dept. or agency at the request of client/consumer.



STATE OF MISSOURI AUTHORIZATION FOR DISCLOSURE OF CONSUMER MEDICAL/HEALTH INFORMATION

I, Fred J. Smith (NAME OF CONSUMER, PARENT, GUARDIAN/LEGAL REPRESENTATIVE) authorize and request

Check all that apply:

- Department of Mental Health (DMH), Department of Health and Senior Services (DHSS), Department of Social Services (DSS), Department of Elementary and Secondary Education (DESE), Other: DESE-DVR; George Q. Professional; 1500 A Southridge Jefferson city, mo 65109

to disclose/release the below specified information of:

NAME: Fred J. Smith, DATE OF BIRTH: 12-1-1958, SOCIAL SECURITY NUMBER: XXX-XX-XXXX

WHO RECEIVED SERVICES FROM (DATES): DVR open case 1999 to present (dates are approximate)

to (check all that apply)

- Department of Mental Health (DMH), Department of Health and Senior Services (DHSS), Department of Social Services (DSS), Department of Elementary and Secondary Education (DESE), Other: Fulton State Hospital, 1 Hospital Drive; Fulton, mo 65111

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

- Eligibility Determination, Assessment, Aftercare, Placement, Transfer/Treatment, Treatment Planning, Continuity of Services/Care, Conditional/Unconditional Release Hearing, At Consumer's Request, To share or refer my information to other Missouri state agencies...

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

- Discharge Summary, Progress Notes, Treatment Plan and/or Review, Social Service Assessment, Educational testing, IEP, transcript, and/or grading reports, Medical/Psychiatric Assessment(s), Psychometric testing, including intelligence quotient (IQ) results, neurological testing, or other developmental test results, Other: Vocational Rehabilitation Records

- 1. READ CAREFULLY:** I understand that my medical/health information records are confidential. I understand that by signing this authorization, I am allowing the release of my medical/health information. The protected health information (PHI) in my medical record includes mental/behavioral health information. In addition, it may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), other communicable diseases, and/or alcohol/drug abuse.
- Alcohol and drug abuse information records are specifically protected by federal regulations (42 CFR 2) and by signing this authorization without restrictions I am allowing the release of any alcohol and/or drug information records (if any) to the agency or person specified above. Please sign if you are authorizing the release of alcohol and drug abuse information:

G

*'All Clients Sign here'*

- This authorization includes both information presently compiled and information to be compiled during the course of treatment at the above-named facility or agency paying for services, during the specified time frame.
- This authorization becomes effective on 1-31-2003. This authorization automatically expires on the following date, event or special condition Closure of case with DVR
- If I fail to specify an expiration date, this authorization will expire in one year.
- 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 health information management department (medical records) or client information center at this facility. I further understand that actions already taken based on this authorization, prior to revocation, will **NOT** be affected.
- I understand that I have the right to receive a copy of this authorization. **A photographic copy of this authorization is as valid as the original.**
- I understand that authorizing the disclosure of this medical/health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may request to inspect or request a copy of information to be used or disclosed, as provided in 45 CFR Section 164.524. I understand that any disclosure of information carries with the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my medical/health information, I can contact the health information management director (medical records director) or client information center, or designee, or the Privacy Officer for this covered entity.

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My signature below acknowledges that I have read, understand, and authorize the release of my PHI.

SIGNATURE OF CONSUMER	DATE
<i>Client/Consumer Signature</i>	<i>Date</i>
WITNESS	DATE
<i>Counselor or other Witness Signature</i>	<i>Date</i>
SIGNATURE OF PARENT/LEGAL GUARDIAN/REPRESENTATIVE	
<i>Parent/Legal Guardian Signature if Applicable</i>	

I

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

**NOTICE OF REVOCATION**

DATE
<i>Date of Revocation</i>

I, *Print client name here*, (Consumer) 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.

J

SIGNATURE OF CONSUMER	DATE
<i>Client/Consumer Signature</i>	<i>Date</i>
WITNESS	DATE
<i>Counselor or other Witness Signature</i>	<i>Date</i>
SIGNATURE OF PARENT/LEGAL GUARDIAN/REPRESENTATIVE	DATE
<i>Parent/Legal Guardian Signature if Applicable</i>	<i>Date</i>

If you choose to revoke your authorization, please provide a copy of the completed revocation to the health information management director (medical records director), or the client information center, or to the Privacy Officer of this facility.