AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

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: HIPAA Privacy Official, 1000 W. Nifong, Building 7, Suite 210, 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)

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: _______________________
____________________________________________________________________________.)