University of Missouri System

COLUMBIA | KANSAS CITY | ROLLA | ST. LOUIS

Authorization for Release of Health Information

I, _____ (*name of individual*), 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. The following is conditioned upon providing this authorization:

6. I understand this authorization will expire on _____.
7. 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
   1105 Carrie Francke Dr,
   Suite 108
   Columbia, MO 65211.

8. I understand the revocation is only effective after it is received by The Curators of the University of Missouri.
9. I understand 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.
10. I understand after this information is disclosed, state or federal law might not protect it and the recipient might re-disclose it.
11. I understand I am entitled to receive a copy of this authorization.
12. I agree and understand a photocopy or facsimile copy of this authorization will be as valid as the original.

I acknowledge and agree that this document may be signed by electronic signature, which shall be considered an original signature for all purposes and shall have the same force and effect as an original signature. “Electronic signature” shall include faxed versions of an original signature, electronically scanned and transmitted versions of an original signature and typed signature in a fillable form or typed signature via Adobe Pro.

_____ _____

Signature of Individual **Date**

Updated: 07/29/2020