SOUTHEAST MISSOURI STATE UNIVERSITY

Please check the appropriate Health Care Component

❒Self-funded Health Plan ❒Health Clinic ❒Autism Center

AUTHORIZATION FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize the use and/or disclosure of my protected health information as described below:

1. My authorization applies to the information described below. Only this information may be used and/or disclosed pursuant to this authorization: _____

_____

_____

2. I authorize the Southeast Missouri State University Health Care Component indicated on this form to make the authorized use and/or disclosure of the above protected health information.

3. I authorize the following persons (or class of persons) to receive my protected health information:

_____

_____

4. I understand that, if my protected health information is disclosed to someone who is not required to comply with state and federal privacy laws and regulations, then such information may be re-disclosed and would no longer be protected.

5. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing (on this form or by a letter). I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

6. This authorization expires upon _____. A copy of this authorization shall be as valid as an original.

7. Southeast Missouri State University will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

8. My protected health information will be used or disclosed upon request for the following purposes (please name and explain each purpose): _____

_____

_____

I certified that I have received a copy of the authorization.

Signature of Patient or Personal Representative	Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority

A SIGNED COPY OF THIS AUTHORIZATION MUST BE PROVIDED TO THE PATIENT OR THE PATIENT'S REPRESENTATIVE