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MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF AMBULATORY CARE

CAREGIVER, ADVISE, RECORD, AND ENABLE (CARE) ACT RELEASE OF INFORMATION AUTHORIZATION

NAME OF FACILITY		
PATIENT NAME	DATE OF BIRTH (MM/DD/YYYY)	DATE OF DISCHARGE (MM/DD/YYYY)
NAME OF DESIGNATED CAREGIVER	DESIGNATED CAREGIVER PHONE NUMBER	
DESIGNATED CAREGIVER ADDRESS		RELATIONSHIP TO PATIENT

I decline designation of a caregiver. ☐ Yes	INITIALS

The purpose of this Release of Information form is release of aftercare instructions.

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 any and all of my medical/health information whether past, present or created in the future up to the expiration or revocation date of this authorization, unless otherwise indicated. 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), and/or other communicable diseases or environmental diseases and conditions.

2. 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.

3. Unless otherwise indicated, this authorization become effective on the date of signature below and will expire one year from that date.

4. This authorization only applies to the aftercare necessary for services provided related to the date of discharge noted above.

5. 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.

6. 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 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 it 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.

My signature below acknowledges I have read, understand, and authorize the release of my PHI to the caregiver noted above.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN	DATE
PRINTED NAME OF PATIENT OR LEGAL GUARDIAN	RELATIONSHIP TO PATIENT