Consent for Release of Information

(Use this form for information SSA generates and includes on a BPQY)

*SSA will not honor this form unless all required fields have been completed (*signifies required field)*

TO: ***Social Security Administration***

*Name _____ * Date of Birth _____ * Social Security Number _____

I authorize the Social Security Administration to release information or records about me via facsimile, phone, email or postal correspondence, to: **(name, address, agency, contact information including phone and email)**

Name, Title	Contact Information
Pamela Warren, Disability Benefits Specialist	**Center for Human Services 1500 Ewing Drive Sedalia, MO 65301 (660) 826-4400 Extension 539**

I want this information released for benefit planning purposes. I want accurate and current information about my benefits to learn how they would be affected by work. This is a "program–related" purpose.

Please release the following information selected from the list below:

You must check at least one box. Also, SSA will not disclose records unless applicable date ranges are included.

- [X] Current monthly Social Security benefit amount
- [X] Current monthly Supplemental Security Income payment amount
- [X] My Medicare entitlement
- [X] ***Other records necessary (specify below)***

Cash: Type of Benefit(s), current payment status, statutory blindness, date of disability onset, date of entitlement, others paid on the record, total family cash benefit, overpayment balance, monthly amount withheld.
Medical Reviews: Next medical review, medical re-exam cycle
Representation: Representative payee, authorized representative
Title XVI (SSI) Work Exclusion: Blind work expenses, impairment-related work expenses, student earned income exclusions, PASS exclusion, SSI earnings
Title II (SSDI) Work Exclusion: Trial Work Period start/end date, months used, month of cessation, and last work review action.
SSI/SSDI Posted Monthly Earnings for last 5 years

Additional Information Requested:

IRWE and/or Subsidy Information: Please provide specifics for any IRWE and/or subsidy, if applicable
Ticket-to-Work: If a "ticket" is assigned, please indicate when was it assigned, and include the EN's contact information.
1619b Status: If the person is in non-pay due to wages, do they have 1619b status?
What is the disabling condition(s) for which I receive benefits?

Other necessary information requested:

_____

_____

This release is valid for 1 year from the date of my signature. I am the individual, to whom the requested information/record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury in accordance with 28 C.F.R. § 16.41(d)(2004) that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that any applicable fees must be paid by me.

Signature: _____

(Show signatures, names and addresses of two people if signed by mark.)

*Date: _____ *Relationship: (if not the individual) _____

*Daytime Phone: _____

Center for Human Services

Authorization to Release and Use Protected Health Information

I authorize Center for Human Services (CHS) to release, Obtain, or Transfer information on:

Name of Individual: _____ Date of Birth: _____

OBTAIN FROM:	DISCLOSE TO:
☐ CHS ☐ Family Support Division ☐ SSA ☐ Sedalia #200 School District ☐ DESE/VOC Rehab ☒ Other _____ Name of Agency or Person Include address, phone, and/or fax based on how records are to be transferred Address: _____ _____ Phone: _____ Fax: _____ To the Attention of: _____	☒ CHS ☐ Family Support Division ☐ SSA ☐ Sedalia #200 School District ☐ DESE/VOC Rehab ☐ Other _____ Name of Agency or Person Include address, phone, and/or fax based on how records are to be transferred Address: 1500 Ewing Drive Sedalia, MO 65301 Phone: 660-826-4400 Fax: 866-234-8056 To the Attention of: Employment Services

PURPOSE OF THE RELEASE, TRANSFER OR REQUEST

☒ Continuing care and treatment ☒ Insurance/Payment ☒ Legal
☒ Social Security/Disability ☒ Individual Served Request ☒ Other (Specify) Benefits

SPECIFY INFORMATION REQUESTED

☒ Treatment Plan ☒ Progress Notes ☒ Discharge Summary
☒ History & Physical ☒ Education Records ☒ Financial Records
☒ Juvenile Records ☒ Incarceration Records
☒ Name, Address, Family Composition, Household Income, Race, Age, Gender, Existence of Developmental Disability, Eligibility for Assistance
☒ Other (Specify) Information required to provide services

DATES COVERED BY REQUEST

☒ All Dates ☒ Specify Dates _____ thru _____

READ CAREFULLY

1. I understand that my records are confidential, and that by signing this authorization, I am authorizing the release of my medical/health information. The protected health information (PHI) in my medical record may include: history, diagnosis, and/or treatment or genetic counseling.

☒ _____ Yes, I consent to the release of this information Initials ☐ _____ No, I do not consent to the release of this information Initials

This authorization does not include permission to release Psychotherapy Notes, which are notes of a mental health professional documenting the contents of conversations during private, group or family counseling sessions.

2.	This authorization becomes effective on _____ This authorization automatically expires on the follow date, event or condition: _____ _____ If I fail to specify an expiration date, this authorization will expire one year following signature of authorization.
3.	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 send my written revocation to the Privacy Officer at CHS, 1500 Ewing Drive, Sedalia, MO 65301. I further understand that actions already taken based on this authorization, prior to revocation, will **not** be affected.
4.	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.**
5.	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. If I have questions about disclosure of my medical/health information, I can contact the Privacy Officer.
6.	I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
7.	The Center for Human Services will not receive any financial or in-kind compensation in exchange for using or disclosing the health information listed above.

My signature below acknowledges that I have read, understand, and authorize the release of the information stated above.

Signature of Individual: _____ Date: _____

Signature of Witness: _____ Date: _____

Signature of Parent/Legal
Guardian/Representative: _____ Date: _____

*Authority to act on individual served's behalf, including appointment of legal guardian or personal representative, must be on file with the Agency

NOTICE OF REVOCATION

I, _____ (individual served) 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 Individual: _____ Date: _____

Signature of Witness: _____ Date: _____

Signature of Parent/Legal
Guardian/Representative: _____ Date: _____

*Authority to act on individual served's behalf, including appointment of legal guardian or personal representative, must be on file with the Agency

Center for Human Services

Authorization to Release and Use Protected Health Information

I authorize Center for Human Services (CHS) to release, Obtain, or Transfer information on:

Name of Individual: _____ Date of Birth: _____

OBTAIN FROM:	DISCLOSE TO:
☐ CHS ☐ Family Support Division ☐ SSA ☐ Sedalia #200 School District ☐ DESE/VOC Rehab ☒ Other Department of Mental Health/CIMOR Name of Agency or Person Include address, phone, and/or fax based on how records are to be transferred * Address: 1706 E Elm St. Jefferson City, MO 65101 Phone: 573-751-4122 Fax: 573-751-8224 To the Attention of: *information may be shared via secured email with DMH/CMRO	☒ CHS ☐ Family Support Division ☐ SSA ☐ Sedalia #200 School District ☐ DESE/VOC Rehab ☐ Other _____ Name of Agency or Person Include address, phone, and/or fax based on how records are to be transferred Address: 1500 Ewing Drive Sedalia, MO 65301 Phone: 660-826-4400 Fax: 866-234-8056 To the Attention of: Employment Services specified designee

PURPOSE OF THE RELEASE, TRANSFER OR REQUEST

☒ Continuing care and treatment ☒ Insurance/Payment ☒ Legal
☒ Social Security/Disability ☐ Individual Served Request ☒ Other (Specify) Benefits Planning

SPECIFY INFORMATION REQUESTED

☒ Treatment Plan ☐ Progress Notes ☐ Discharge Summary
☐ History & Physical ☐ Education Records ☒ Financial Records
☐ Juvenile Records ☐ Incarceration Records
☒ Name, Address, Family Composition, Household Income, Race, Age, Gender, Existence of Developmental Disability, Eligibility for Assistance
☒ Other (Specify) Information specific HCBW services, funding, benefits, diagnosis, demographics, authorizations

DATES COVERED BY REQUEST

☐ All Dates ☐ Specify Dates _____ thru _____

READ CAREFULLY

1. I understand that my records are confidential, and that by signing this authorization, I am authorizing the release of my medical/health information. The protected health information (PHI) in my medical record may include: history, diagnosis, and/or treatment or genetic counseling.

☒ _____ Yes, I consent to the release of this information Initials ☐ _____ No, I do not consent to the release of this information Initials

This authorization does not include permission to release Psychotherapy Notes, which are notes of a mental health professional documenting the contents of conversations during private, group or family counseling sessions.

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4.	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.**
5.	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. If I have questions about disclosure of my medical/health information, I can contact the Privacy Officer.
6.	I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
7.	The Center for Human Services will not receive any financial or in-kind compensation in exchange for using or disclosing the health information listed above.

My signature below acknowledges that I have read, understand, and authorize the release of the information stated above.

Signature of Individual: _____ Date: _____

Signature of Witness: _____ Date: _____

Signature of Parent/Legal
Guardian/Representative: _____ Date: _____

*Authority to act on individual served's behalf, including appointment of legal guardian or personal representative, must be on file with the Agency

NOTICE OF REVOCATION

I, _____ (individual served) 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 Individual: _____ Date: _____

Signature of Witness: _____ Date: _____

Signature of Parent/Legal
Guardian/Representative: _____ Date: _____

*Authority to act on individual served's behalf, including appointment of legal guardian or personal representative, must be on file with the Agency

Center for Human Services

Authorization to Release and Use Protected Health Information

I authorize Center for Human Services (CHS) to release, Obtain, or Transfer information on:

Name of Individual: _____ Date of Birth: _____

OBTAIN FROM:	DISCLOSE TO:
☐ CHS ☒ Family Support Division ☐ SSA ☐ Sedalia #200 School District ☐ DESE/VOC Rehab ☒ Other MO HealthNet/EMOMED Name of Agency or Person Include address, phone, and/or fax based on how records are to be transferred * Address: 101 Park Central Square Springfield, MO 65806 Phone: 1-855-373-4636 Fax: _____ To the Attention of: email to: FSD.Hospitalapplications@dss.mo.gov OR COLE.MHNPolicy@dss.mo.gov	☒ CHS ☐ Family Support Division ☐ SSA ☐ Sedalia #200 School District ☐ DESE/VOC Rehab ☐ Other _____ Name of Agency or Person Include address, phone, and/or fax based on how records are to be transferred Address: 1500 Ewing Drive Sedalia, MO 65301 Phone: 660-826-4400 Fax: 866-234-8056 To the Attention of: Pam Warren, Disability Benefits Specialist

PURPOSE OF THE RELEASE, TRANSFER OR REQUEST

☐ Continuing care and treatment ☐ Insurance/Payment ☐ Legal
☒ Social Security/Disability ☐ Individual Served Request ☒ Other (Specify) Benefits Planning

SPECIFY INFORMATION REQUESTED

☐ Treatment Plan ☐ Progress Notes ☐ Discharge Summary
☐ History & Physical ☐ Education Records ☒ Financial Records
☐ Juvenile Records ☐ Incarceration Records
☒ Name, Address, Family Composition, Household Income, Race, Age, Gender, Existence of Developmental Disability, Eligibility for Assistance
☒ Other (Specify) Information specific to Medicaid, Medicaid Waiver, Food Stamps (SNAP) or TANF & EMOMED

DATES COVERED BY REQUEST

☐ All Dates ☐ Specify Dates _____ thru _____

READ CAREFULLY

1. I understand that my records are confidential, and that by signing this authorization, I am authorizing the release of my medical/health information. The protected health information (PHI) in my medical record may include: history, diagnosis, and/or treatment or genetic counseling.

☐ _____ Yes, I consent to the release of this information Initials ☐ _____ No, I do not consent to the release of this information Initials

This authorization does not include permission to release Psychotherapy Notes, which are notes of a mental health professional documenting the contents of conversations during private, group or family counseling sessions.

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4.	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.**
5.	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. If I have questions about disclosure of my medical/health information, I can contact the Privacy Officer.
6.	I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
7.	The Center for Human Services will not receive any financial or in-kind compensation in exchange for using or disclosing the health information listed above.

My signature below acknowledges that I have read, understand, and authorize the release of the information stated above.

Signature of Individual: _____ Date: _____

Signature of Witness: _____ Date: _____

Signature of Parent/Legal
Guardian/Representative: _____ Date: _____

*Authority to act on individual served's behalf, including appointment of legal guardian or personal representative, must be on file with the Agency

NOTICE OF REVOCATION

I, _____ (individual served) 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 Individual: _____ Date: _____

Signature of Witness: _____ Date: _____

Signature of Parent/Legal
Guardian/Representative: _____ Date: _____

*Authority to act on individual served's behalf, including appointment of legal guardian or personal representative, must be on file with the Agency

Center for Human Services

Authorization to Release and Use Protected Health Information

I authorize Center for Human Services (CHS) to release, Obtain, or Transfer information on:

Name of Individual: _____ Date of Birth: _____

OBTAIN FROM:	DISCLOSE TO:
☐ CHS ☐ Family Support Division	☒ CHS ☐ Family Support Division
☒ SSA ☐ Sedalia #200 School District	☐ SSA ☐ Sedalia #200 School District
☐ DESE/VOC Rehab	☐ DESE/VOC Rehab
☐ Other _____ (Name of Agency or Person)	☐ Other _____ (Name of Agency or Person)
Include address, phone, and/or fax based on how records are to be transferred *	Include address, phone, and/or fax based on how records are to be transferred
Address: 3404 W 10th Sedalia, MO 65301	Address: 1500 Ewing Drive Sedalia, MO 65301
Phone: 877-405-5459 Fax: 660-827-3049	Phone: 660-826-4400 Fax: 866-234-8056
To the Attention of: Bret Kuhns or Joyce Brockhaus (or assigned Representative)	To the Attention of: Pam Warren, Disability Benefits Specialist
*information may be shared via email with Social Security	

PURPOSE OF THE RELEASE, TRANSFER OR REQUEST

☐ Continuing care and treatment ☐ Insurance/Payment ☐ Legal
☐ Social Security/Disability ☐ Individual Served Request ☒ Other (Specify) Benefits Planning

SPECIFY INFORMATION REQUESTED

☐ Treatment Plan ☐ Progress Notes ☐ Discharge Summary
☐ History & Physical ☐ Education Records ☒ Financial Records
☐ Juvenile Records ☐ Incarceration Records
☒ Name, Address, Family Composition, Household Income, Race, Age, Gender, Existence of Developmental Disability, Eligibility for Assistance
☒ Other (Specify) Information specific to Title II or SSI benefits and Medicare eligibility

DATES COVERED BY REQUEST

☐ All Dates ☐ Specify Dates _____ thru _____

READ CAREFULLY

1. I understand that my records are confidential, and that by signing this authorization, I am authorizing the release of my medical/health information. The protected health information (PHI) in my medical record may include: history, diagnosis, and/or treatment or genetic counseling.

☐ _____ Yes, I consent to the release of this information (Initials) ☐ _____ No, I do not consent to the release of this information (Initials)

This authorization does not include permission to release Psychotherapy Notes, which are notes of a mental health professional documenting the contents of conversations during private, group or family counseling sessions.

2.	This authorization becomes effective on _____ This authorization automatically expires on the follow date, event or condition: _____ _____ If I fail to specify an expiration date, this authorization will expire one year following signature of authorization.
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5.	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. If I have questions about disclosure of my medical/health information, I can contact the Privacy Officer.
6.	I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
7.	The Center for Human Services will not receive any financial or in-kind compensation in exchange for using or disclosing the health information listed above.

My signature below acknowledges that I have read, understand, and authorize the release of the information stated above.

Signature of Individual: _____ Date: _____

Signature of Witness: _____ Date: _____

Signature of Parent/Legal
Guardian/Representative: _____ Date: _____

*Authority to act on individual served's behalf, including appointment of legal guardian or personal representative, must be on file with the Agency

NOTICE OF REVOCATION

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Signature of Individual: _____ Date: _____

Signature of Witness: _____ Date: _____

Signature of Parent/Legal
Guardian/Representative: _____ Date: _____

*Authority to act on individual served's behalf, including appointment of legal guardian or personal representative, must be on file with the Agency

Consent for Release of Information

(Use this form for the non-certified yearly earnings provided on the BPQY)

*SSA will not honor this form unless all required fields have been completed (*signifies required field)*

TO: ***Social Security Administration***

*Name	* Date of Birth	* Social Security Number

I authorize the Social Security Administration to release information or records about me via facsimile, phone, email or postal correspondence, to: **(name, address, agency, contact information including phone and email)**

Name, Title	Contact Information
Pamela Warren, Disability Benefits Specialist	**Center for Human Services 1500 Ewing Drive Sedalia, MO 65301 (660) 826-4400 Extension 539**

I want this information released for benefit planning purposes. I want accurate and current information about my benefits to learn how they would be affected by work. This is a "program–related" purpose.

Please release the following information listed below:

☒ **Non-certified yearly totals of my earnings from my date of birth to the present.**

Other necessary information requested:

_____

_____

This release is valid for 1 year from the date of my signature. I am the individual, to whom the requested information/record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury in accordance with 28 C.F.R. § 16.41(d)(2004) that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that any applicable fees must be paid by me.

Signature: _____

(Show signatures, names and addresses of two people if signed by mark.)

*Date: _____ *Relationship: (if not the individual) _____

*Daytime Phone: _____