



Branson Police Department
110 W Maddux, Suite 100
Branson, Missouri 65616
417.334.3300 Office
417.334.5530 Fax

AUTHORIZATION FOR DISCLOSURE OF CONSUMER
MEDICAL/HEALTH INFORMATION

I, _____ authorize and request the below specified information to be disclosed/released to the Branson Police Department for dissemination to their staff and other emergency services, as may be necessary for the immediate response and care of the below listed individual.

Consumer name: _____

Date of birth: _____

Social Security #: _____

Drivers license/State issued ID #: _____

Address (Specify if natural home, group home or Individualized Supported Living (ISL) Apartment): _____

Home Phone #: _____

Legally Responsible Party: _____

Responsible Party's Address: _____

Home Phone #: _____

Alternate #'s: _____

Physical description: (color of hair, eyes, weight, height, birth marks, paralysis, braces, cane, seizures etc.)

Disability Types: Visually impaired ___ On Life Support ___ Oxygen ___

Hearing Impaired ___ Bedridden ___ Require IV ___

Wheelchair ___ Speech Impairment ___

Ventilator ___ Feeding Tube ___

Developmentally ___

Other Medical Conditions:

Mobility: (check all that apply)

I am able to provide my own transportation

I am bedridden and require a stretcher transport

I am ambulatory with assistance

I need a wheelchair lift equipped vehicle

Emergency contact name and numbers:

1. _____
2. _____
3. _____
4. _____

Diagnosis: _____

Does the Consumer receive services from the Department of Mental Health? _____ . If the answer is yes please provide:

Name of support agency _____

Contact person at agency _____

Contact person phone numbers: _____

Significant Medical Information: _____

Capabilities or limitations: _____

Behavior Issues: _____

Primary care Physician: (name and phone #) _____

Psychiatrist: (name and phone #) _____

Response Strategies: (How the authorities should approach the individual or situation?) _____

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 my medical/health information. 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), other communicable diseases, and/or alcohol/drug abuse.
2. Alcohol and drug abuse information records are specifically protected by federal regulations (42 CFR 2) and by signing this authorization without restrictions I am allowing the release of any alcohol and/or drug information records (if any) to the agency or person specified above. Please sign if you are authorizing the release of alcohol and drug abuse information:

3. This authorization includes both information presently compiled and information to be compiled during the course of treatment at the above-named facility during the specified time frame.
4. This authorization becomes effective on _____. This authorization automatically expires on the following date, event or special condition.
5. If you fail to specify an expiration date, this authorization will expire in one year.
6. 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 Branson Police Department. I further understand that actions already taken based on this authorization, prior to revocation, will **not** be affected.

7. 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.**
8. I understand that authorizing the disclosure of this medical/health information is voluntary. I can refuse to sign this authorization. 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 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 Branson Police Department.
9. **THE FOLLOWING STATEMENT APPLIES TO ANY ALCOHOL AND/OR DRUG ABUSE TREATMENT INFORMATION RECORDS THAT WE DISCLOSE:** Prohibition on Redisclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibit you from making further disclosure of it without the specific written authorization of the person to whom it pertains, or as otherwise specified by such regulations. A general authorization for disclosure of medical or other information is NOT sufficient for this purpose.

My signature below acknowledges that I have read, understand, and authorize the release of my PHI

Signature of Consumer: _____ Date: _____

Signature of Witness: _____ Date: _____

Signature of Parent/Legal

Guardian/Representative: _____ Date: _____

(Please provide a Description of Authority to act on Consumer's behalf)

NOTICE OF REVOCATION

I, _____ (Consumer) 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 Consumer: _____	Date: _____
Signature of Witness: _____	Date: _____
Signature of Parent/ Legal Guardian/Representative: _____	Date: _____

If you choose to revoke your authorization, please provide a copy of the completed revocation to the Branson Police Department.