HIPPA AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION AND NONPUBLIC PERSONAL INFORMATION

Name: _____

Social Security #: _____

Date of Birth: _____

The undersigned insured(s) (hereafter referred to as "I"), authorizes the use and disclosure of my personal health and medical information protected by state and federal law including the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that certain information in these records cannot be released without specific authorization because of federal or state laws. By initialing the following areas, I specifically authorize the release of confidential information.

_____ All Information

_____ HIV test results and related information

_____ Drug/Alcohol diagnosis, treatment, or referral information

_____ Mental Health treatment information

_____ Other _____

I further authorize the return of the medical records to the following address listed below:

OCI
17445 Arbor St, Suite 310
Omaha, NE 68130

Missouri Farm Bureau
701 S. Country Club Drive
Jefferson City, MO 65102

My consent may be revoked at any time. The only exception is when the action has already occurred as instructed in the consent.

Signature: _____ Date: _____

Parent/Legal Guardian signature (if applicable): _____