BI-STATE DEVELOPMENT AGENCY (METRO)

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Name of Participant: ___________________________ Social Security Number: ____________

I hereby authorize the use or disclosure of my individually identifiable health information as described below. *I understand that this Authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing as provided for below.*

I. Information About the Use or Disclosure

Specific person(s) or class of persons authorized to provide the information: ________________

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Specific person(s) or class of persons authorized to receive and use the information: __________

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____

Specific and meaningful description of information to be used or disclosed (include date(s)): ___

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Specific purpose of the request. (If you do not wish to state a purpose, please state, "At the request of the Participant."): ____

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Expiration date of this authorization. (Indicate an expiration date, or an expiration event relating to you personally or to the purpose of the authorization): _________________________________

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II. Important Information About Your Rights

I have read and understood the following statements about my rights:

- I may revoke this Authorization at any time prior to its expiration date. In order to revoke this Authorization, I must notify the Director of Benefits Office of Bi-State Development Agency (METRO) in writing at 211 North Broadway, Suite 700, St. Louis, MO 63102-2759. I understand that any disclosure prior to the revocation in accordance with this Authorization will not be affected by a revocation.
- I understand that I am entitled to receive a copy of this Authorization.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form in order to receive my health care benefits (enrollment, treatment, or payment).
- The information that is used or disclosed pursuant to this Authorization may be re-disclosed by the receiving entity.

III. Signature of Participant or Participant's Personal Representative

____ _____________________________

Signature of participant or participant's personal representative (*Form MUST be completed before signing.*)

Date

Printed name of the participant's personal representative:________________________________

If the Authorization is signed by the personal representative of the participant, please provide a description of the personal representative's relationship to the participant, including a description of such representative's authority to act for the participant:______________________________

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Identity of participant or personal representative verified via:

- ❑ Photo ID
- ❑ Matching signature
- ❑ Other ____

Verified by ____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION