AUTHORIZATION FOR RELEASE OF MEDICAL/HEALTH INFORMATION

I, _____ do hereby request by court order
(COURT APPOINTED SPECIAL ADVOCATE)

that _____ release or disclose to
(NAME OF ENTITY OR INDIVIDUAL **HOLDING THE RECORDS**)

_____
(NAME OF COURT APPOINTED SPECIAL ADVOCATE TO RECEIVE THE RECORDS) (ADDRESS/EMAIL ADDRESS)

the health information for the individual listed below.

NAME ON INFORMATION TO BE DISCLOSED	BIRTH DATE	

THE SPECIFIC INFORMATION TO BE DISCLOSED IS (CHECK ALL THAT APPLY)

- ☒ Entire Record
- ☒ Laboratory Reports
- ☒ Psychological Evaluation
- ☒ Medical History, Examinations, Diagnosis
- ☒ Hospital Records Including Reports
- ☒ Mental Health Records/Reports
- ☐ Healthcare Payments
- ☐ Other (Specify): _____

Dates of Service, if appropriate: _____

PURPOSE OF REQUEST FOR DISCLOSURE

- ☐ At the request of the individual or the individual's legal representative
- ☒ Other (Specify): FOR PURPOSES OF UPDATING THE JUVENILE COURT ON THE WELLBEING OF THE CHILD

NOTES: Please provide an electronic copy of the records requested to the email provided below. As a representative a small non-profit, funds are limited. Please provide the records at no cost.

SIGNATURE: DATE:

ATTACHMENT- COURT ORDER — COURT ORDER SECTION 4 AUTHORITY FOR MEDICAL REQUESTS PURSUANT TO § 210.160(6)

PLEASE RETURN REQUESTED INFORMATION TO

COURT APPOINTED SPECIAL ADVOCATE	TELEPHONE NUMBER

ADDRESS (STREET, CITY, STATE, ZIP CODE) EMAIL

P.O. Box 1627, Jefferson City, MO 65102