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 produce an electronic copy of the records requested to the email provided below. As a representative of a small non-profit children's advocacy group, funds are very limited. Please give consideration to providing the records at no cost to aid our ability to serve the community. If you are unable to do so, please contact the CASA office at 573-893-2272 to discuss costs and payment options.

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