



STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION
AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH
INFORMATION PURSUANT TO THE HEALTH INSURANCE
PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

CENTRAL INVESTIGATIONS UNIT
 POST OFFICE BOX 1335
 JEFFERSON CITY, MO 65102
 TELEPHONE (573) 526-0162
 FAX (573) 751-5649
 TDD 800-735-2966

PATIENT	
SOCIAL SECURITY NUMBER	DATE OF BIRTH

1. I authorize the use and disclosure of protected health information as described below; and,
2. Authorize and request: _____ (name of health care provider)
3. TO RELEASE THE FOLLOWING INFORMATION: any and all billing records; medical records charts; medical reports; chart notes; clinical notes; x-rays and/or radiographic studies and reports of the same; reports of consultation; patient histories/patient questionnaires; reports and records of laboratory testing and other testing; any and all correspondence (in any format) and any other records and documents contained in my file; or, if applicable, for each admission, whether In-Patient, Out-patient, or Emergency Room, the entire record for each admission, to include admitting history & physical; discharge summary; reports of consultation; reports and records of laboratory testing and other testing; reports of consultation; x-rays and radiographic studies and reports of the same; and other records and documents for each admission;
4. Covering all past, present, and future periods of health care; OR Covering the period of health care from _____ to _____
5. The requested information is to be released to the Central Investigations Unit of the Missouri Division of Professional Registration (CIU), P.O. Box 1335, Jefferson City, MO 65102.
6. The requested information is to be used or disclosed for the purpose of oversight activities authorized by law, including audits; civil, administrative, or criminal investigations, inspections, licensure, or disciplinary proceedings or actions; or other activities necessary for the CIU or entities subject to government regulatory programs for which information is necessary for determining compliance with program standards.
7. This authorization shall be in force and effect and not expire until (a) I exercise my right of revocation, as described below, (b) the occurrence of the following date/event _____, or (c) one year from the date of execution, whichever occurs first. A photocopy of this authorization is as valid as an original.
8. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so by communicating in writing, with specific reference to this authorization, to the health care provider named in paragraph 2, above, and to the CIU. I understand that the revocation will not apply to information that has already been released in response to this authorization.
9. I understand that I may refuse to sign this authorization. I further understand that the health care provider named in paragraph 2 may not condition treatment, payment, enrollment in a health plan, or eligibility for benefits on whether I sign this authorization.
10. I understand that after information is disclosed pursuant to this authorization, it is possible that the information may be redisclosed by the recipient and would no longer be protected by applicable medical privacy laws.
11. I understand that the information in the requested health record may include information relating to Hepatitis B or C, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), and/or human immunodeficiency virus (HIV). It may also contain information about behavioral or mental health services, psychiatric and/or psychological evaluation testing and/or treatment, and treatment for alcohol and drug abuse.
12. I understand that any information disclosed pertaining to alcohol/drug abuse is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit the recipient of such information from making any further disclosure unless further disclosure is expressly permitted by my written consent or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of such information to criminally investigate or prosecute any alcohol or drug abuse patient.

SIGNATURE OF PATIENT, PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE	DATE
RELATIONSHIP TO PATIENT	SIGNATURE OF WITNESS (OPTIONAL)

Personally appeared before me, the above-named Patient, Parent/Guardian, or Authorized Representative, known to me to be the person described in and who executed the foregoing instrument, and acknowledged that he or she executed the same as his or her free act and deed. In testimony thereof, I have hereunto set my hand and affixed my official seal, in the state and county aforesaid, the day, month, and year above written.

NOTARY PUBLIC EMBOSSE OR BLACK INK RUBBER STAMP SEAL	STATE	COUNTY (OR CITY OF ST. LOUIS)	
	SUBSCRIBED AND SWORN BEFORE ME, THIS		
	DAY OF	YEAR	USE RUBBER STAMP IN CLEAR AREA BELOW.
	NOTARY PUBLIC SIGNATURE	MY COMMISSION EXPIRES	
NOTARY PUBLIC NAME (TYPED OR PRINTED)			



STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION
UNIFORM COMPLAINT

CENTRAL INVESTIGATIONS UNIT
 POST OFFICE BOX 1335
 JEFFERSON CITY, MO 65102
 TELEPHONE (573) 526-0162
 FAX (573) 751-5649
 TDD 800-735-2966

Section 575.060 – False Declarations. Whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his official duty may be guilty of a Class B misdemeanor. PLEASE TYPE OR PRINT IN BLACK INK

I WOULD LIKE TO FILE MY COMPLAINT WITH THE FOLLOWING BOARD:

- | | |
|---|--|
| <input type="checkbox"/> BEHAVIOR ANALYST ADVISORY BOARD | <input type="checkbox"/> COMMITTEE FOR SOCIAL WORKERS* |
| <input type="checkbox"/> BOARD FOR OCCUPATIONAL THERAPY* | <input type="checkbox"/> COMMITTEE OF DIETITIANS* |
| <input type="checkbox"/> BOARD FOR RESPIRATORY CARE* | <input type="checkbox"/> COMMITTEE OF INTERPRETERS* |
| <input type="checkbox"/> BOARD OF CHIROPRACTIC EXAMINERS* | <input type="checkbox"/> COMMITTEE OF MARITAL AND FAMILY THERAPISTS* |
| <input type="checkbox"/> BOARD OF EMBALMERS AND FUNERAL DIRECTORS | <input type="checkbox"/> COMMITTEE OF PSYCHOLOGISTS* |
| <input type="checkbox"/> BOARD OF EXAMINERS FOR HEARING INSTRUMENT SPECIALISTS* | <input type="checkbox"/> INTERIOR DESIGN COUNCIL |
| <input type="checkbox"/> BOARD OF GEOLOGISTS REGISTRATION | <input type="checkbox"/> OFFICE OF ATHLETICS |
| <input type="checkbox"/> BOARD OF PODIATRIC MEDICINE* | <input type="checkbox"/> OFFICE OF ENDOWED CARE CEMETERIES |
| <input type="checkbox"/> BOARD OF PRIVATE INVESTIGATOR EXAMINERS | <input type="checkbox"/> OFFICE OF TATTOOING, BODY PIERCING & BRANDING |
| <input type="checkbox"/> BOARD OF THERAPEUTIC MASSAGE* | <input type="checkbox"/> REAL ESTATE APPRAISERS COMMISSION |
| <input type="checkbox"/> COMMITTEE FOR PROFESSIONAL COUNSELORS* | <input type="checkbox"/> OTHER _____ |

*** YOU MUST COMPLETE THE ATTACHED RELEASE FORM FOR THE BOARD, COMMISSION OR COMMITTEE MARKED WITH AN ASTERISK (*). WITH THE RELEASE FORM SIGNED THE CENTRAL INVESTIGATIONS UNIT CAN OBTAIN YOUR MEDICAL OR THERAPEUTIC RECORDS.**

INFORMATION ABOUT YOU

YOUR NAME	TELEPHONE (DAYTIME)	CELL	TELEPHONE (EVENING)
ADDRESS (STREET, CITY, STATE, ZIP)			YOUR OCCUPATION
PREFERRED CONTACT	TELEPHONE	CELL	EMAIL

INFORMATION ABOUT LICENSEE OR PERSON PRACTICING WITHOUT A LICENSE

PERSON NAME AND/OR COMPANY	TELEPHONE
ADDRESS (STREET, CITY, STATE, ZIP)	PROFESSION
	LICENSE NO. (IF KNOWN)

	YES	NO		YES	NO
HAVE YOU CONTACTED LICENSEE OR UNLICENSED INDIVIDUAL ABOUT YOUR COMPLAINT? IF YES, DATE _____	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU CONTACTED AN ATTORNEY?	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU HAD A PROFESSIONAL OR SOCIAL RELATIONSHIP WITH THE PERSON YOU ARE FILING THE COMPLAINT AGAINST? IF SO, PLEASE EXPLAIN _____	<input type="checkbox"/>	<input type="checkbox"/>	HAS A LAWSUIT BEEN FILED?	<input type="checkbox"/>	<input type="checkbox"/>
			IT MAY BE NECESSARY FOR YOU TO TESTIFY AT A HEARING. ARE YOU WILLING TO TESTIFY?	<input type="checkbox"/>	<input type="checkbox"/>

ALL PERTINENT DOCUMENTS NEED TO BE ATTACHED

NAME OF YOUR PRIVATE ATTORNEY (IF APPLICABLE)	TELEPHONE
ADDRESS (STREET, CITY, STATE, ZIP)	

WITNESS: IF WITNESSES ARE LISTED, PLEASE PROVIDE CONTACT INFORMATION

NAME	ADDRESS AND TELEPHONE NUMBER

DETAILS OF COMPLAINT

GIVE FULL DETAILS OF YOUR COMPLAINT. Be specific. What happened? When? **USE BLACK INK.** Type or print legibly. Use additional sheets if necessary. Please attach all pertinent documents regarding this complaint.

Check here if you have included additional sheets or other materials.

NOTICE: All complaints must be signed. Such signature also authorizes the Board/ Committee/Commission to release a copy of the complaint to the licensee who is the subject of the complaint.

SIGNATURE



DATE