



Privacy Request Form

Date of Request: _____

To request member information from Missouri Care, please check one or more of the boxes below.

- Receive copy of privacy practices.
- Receive claim records.
- Change something in member records.
- Receive list of organizations to whom Missouri Care gives out member records.
- Limit how Missouri Care uses and gives out member records.

Member Name: _____ Date of Birth: _____ ID #: _____

Phone: (____) _____

Are you the member? Yes No **If “NO”, tell Missouri Care who you are by checking one of the boxes below. Please give Missouri Care copies of papers that show you have the right to make this request.**

- I am the member’s Dad/Mom or guardian.
- I make health care decisions for the member.
- The member has died, and I take care of his or her estate.
- Other (explain) _____

Name of Requestor (if not member): _____

Please Explain Your Request

Please tell us what you want to receive and why. You need to provide dates of service, names of providers, etc. Missouri Care Plan may charge you to receive copies of member records or a list of people and companies to which we give out member records. You need to tell Missouri Care if you can not pay any fee.

Each member is entitled to one (1) free copy of his or her medical records annually. The fee for additional copies shall not exceed the actual cost of time and materials used to compile, copy, and furnish such records.

Where Do You Want The Records Sent

Address: _____
Street City, State Zip

I (the member or person acting for the member) agree to the following:

- I may authorize Missouri Care to use or give out member records. When I give an approval, Missouri Care will give out member records to a person or company.
- I know that member records can't always be kept safe under privacy laws. I know a person or company that receives member records can give them out again.
- I may take back this authorization by submitting to Missouri Care a request in writing.
- I may not be allowed to take back an authorization in some cases. I can learn more about this in the Missouri Care's Notice of Privacy Practices.
- This authorization will end in twelve (12) months from the date of signature.
- If I want this authorization to end before this date, I will tell Missouri Care when and the reason I want it to end. Use the space below to explain:

- I have read and understand this form.
- I am entitled to receive a copy of this form.

If member - Signature of Member

Date

If member -Print Member Name

Please send this Privacy Request Form to:

**Missouri Care Privacy Officer
2404 Forum Blvd.
Columbia, MO 65203**

Call Missouri Care at 1-800-322-6027 with questions or comments.

Revised: 10/09