



Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

## AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

I HEREBY AUTHORIZE each of the parties named below to receive, use, and/or disclose to each other all of my protected health information:

1. Deseret Mutual Benefit Administrators, including its Missionary Medical Division
2. Representatives/employees of the Missionary Department of The Church of Jesus Christ of Latter-day Saints
3. General Authorities of The Church of Jesus Christ of Latter-day Saints
4. My Mission President and his spouse
5. My home unit priesthood leaders (such as bishop and stake president) and clerks who may assist my local priesthood leaders (such as ward and stake clerks)
6. Missionary Training Center personnel
7. BYU Student Health Center personnel
8. I also authorize my spouse to have access to my protected health information:  Yes  No
9. Others I designate at my discretion as follows:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Birth Date: \_\_\_\_\_

I acknowledge and understand that:

- I received and reviewed Deseret Mutual's Medical Privacy Notice.
- I have a right to a copy of this authorization.
- This authorization is valid from the date of execution until one year after I am released from my mission, unless revoked in writing before that time by sending notice to: Deseret Mutual Benefit Administrators, Attention: Missionary Medical Department, P. O. Box 45730, Salt Lake City, Utah 84145, U.S.A.
- Revocation will be valid only for future acts and will not be valid for any action before receiving my revocation.
- Treatment, payment, enrollment or eligibility for applicable health benefits will not be conditioned upon my providing this authorization except as may otherwise be permitted by applicable law. However, my refusal to sign or my revocation of this form may affect my eligibility to serve or to continue serving as a missionary for The Church of Jesus Christ of Latter-day Saints.
- Any information that is used or disclosed pursuant to this authorization may be subject to redisclosure and may, therefore, no longer be protected by the terms of the privacy rules.
- The use and disclosure of protected health information authorized hereunder is for the purpose of the overall management and administration of my health care while a missionary for The Church of Jesus Christ of Latter-day Saints so that I can be an effective missionary on behalf of, and serve the needs of, the Church.
- The protected health information that may be disclosed includes my history of previous illnesses, symptoms or treatment, as well as current diagnoses, symptoms and treatment. This information may be used to determine my physical or mental fitness or ability to serve as a missionary.

Signature \_\_\_\_\_ Date \_\_\_\_\_



Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

### AUTHORIZATION TO USE AND/OR DISCLOSE PSYCHOTHERAPY NOTES

I HEREBY AUTHORIZE each of the parties named below to receive, use, and/or disclose to each other all of my psychotherapy notes in the event that I suffer from any mental health or emotional related illness:

1. Deseret Mutual Benefit Administrators, including its Missionary Medical Division
2. Representatives/employees of the Missionary Department of The Church of Jesus Christ of Latter-day Saints
3. General Authorities of The Church of Jesus Christ of Latter-day Saints
4. My Mission President and his spouse
5. My home unit priesthood leaders (such as bishop and stake president) and clerks who may assist my local priesthood leaders (such as ward and stake clerks)
6. Missionary Training Center personnel
7. BYU Student Health Center personnel
8. I also authorize my spouse to have access to my protected health information:  Yes  No
9. Others I designate at my discretion as follows:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Birth Date: \_\_\_\_\_

I acknowledge and understand that:

- I received and reviewed Deseret Mutual’s Medical Privacy Notice.
- I have a right to a copy of this authorization.
- This authorization is valid from the date of execution until one year after I am released from my mission, unless revoked in writing before that time by sending notice to: Deseret Mutual Benefit Administrators, Attention: Missionary Medical Department, P. O. Box 45730, Salt Lake City, Utah 84145, U.S.A.
- Revocation will be valid only for future acts and will not be valid for any action before receiving my revocation.
- Treatment, payment, enrollment or eligibility for applicable health benefits will not be conditioned upon my providing this authorization except as may otherwise be permitted by applicable law. However, my refusal to sign or my revocation of this form may affect my eligibility to serve or to continue serving as a missionary for The Church of Jesus Christ of Latter-day Saints.
- Any information that is used or disclosed pursuant to this authorization may be subject to redisclosure and may, therefore, no longer be protected by the terms of the privacy rules.
- The use and disclosure of protected health information authorized hereunder is for the purpose of the over-all management and administration of my health care while a missionary for The Church of Jesus Christ of Latter-day Saints so that I can be an effective missionary on behalf of, and serve the needs of, the Church.
- The protected health information that may be disclosed includes my history of previous illnesses, symptoms or treatment, as well as current diagnoses, symptoms and treatment. This information may be used to determine my physical or mental fitness or ability to serve as a missionary.

Signature \_\_\_\_\_

Date \_\_\_\_\_