MISSIONARY
MEDICAL

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

If you need medical attention, your mission president authorizes doctors and hospitals to provide your care. Medical providers will not share information about your health, known as "protected health information" (PHI), with anyone without your permission. By completing this form, you authorize your mission president and/or Church doctors to be informed of your care.

Name of Individual Whose Information Will Be Released

MISSIONARY NAME	DMBA ID (IF AVAILABLE)	BIRTH DATE

I authorize _____ (medical provider or facility) to disclose my protected health information to the leadership of the _____ Mission, including its Mission President and Medical Adviser.

STREET ADDRESS
CITY, STATE, AND ZIP CODE
TELEPHONE NUMBERS

Information to Be Released: My medical records, including information regarding physical and mental health (excluding psychotherapy notes), all insurance, claims, payment, and benefits information, all symptoms, diagnoses, treatments, prognosis, lab results, medications related to my past, present, or future health.

Purpose for Releasing Information: For the overall evaluation of my health and fitness to serve as a missionary, and for the management and administration of my health care while serving as a missionary for The Church of Jesus Christ of Latter-day Saints.

Expiration Date: 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.

Signature: I certify that the above information is true and complete. I have a right to receive a copy of this authorization. I may revoke this authorization by writing to Deseret Mutual Benefit Administrators, Attention: Missionary Medical Department, P.O. Box 45730, Salt Lake City, UT 84145, USA. Revocation will be valid only for future acts and will not be valid for any action prior to receiving my revocation. Any information used or disclosed pursuant to this authorization may be subject to redisclosure and may, therefore, no longer be protected by privacy regulations.

Treatment, payment, enrollment, or eligibility for applicable medical care will not be conditioned upon my providing this authorization except as may otherwise be permitted by applicable law. However, I understand and agree that my refusal to sign or my revocation of this authorization may affect my eligibility to serve or continue serving as a missionary for The Church of Jesus Christ of Latter-day Saints.

Missionary signature: _____ Date: _____