MISSIONARY
MEDICAL

Authorization to Use and/or Disclose Protected Health Information

Name of Individual Whose Information Will Be Released

Name:_____ DMBA ID or Birth date: _____

Who Can Release Information: The Church of Jesus Christ of Latter-day Saints and its affiliated entities, including Deseret Mutual Benefit Administrators (DMBA), DMBA's business associates, and any and all healthcare providers and/or facilities (including mental health professionals) who have treated me before or after this authorization.

Who Can Receive Information

1. DMBA, including its Missionary Medical Department
2. Representatives and employees of the Missionary Department and the Risk Management Division 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. This includes historic site presidents, temple presidents, and visitors' center directors and their spouses
5. Individuals serving on the Mission Health Council
6. My home unit priesthood leaders (such as bishop and stake president) and clerks who may help my local priesthood leaders (such as ward and stake clerks)
7. Missionary Training Center personnel
8. BYU Student Health Center personnel
9. My parents or guardians as indicated below (if a box is not checked, "yes" is assumed):

   ❑ Yes ❑ No Name: _____ Relationship:_____ Birth date: _____

   ❑ Yes ❑ No Name: _____ Relationship:_____ Birth date: _____
10. Others I designate at my discretion as follows:

    Name: _____ Relationship:_____ Birth date: _____

    Name: _____ Relationship:_____ Birth date: _____

Information to Be Released: My protected health information (PHI). PHI is individually identifiable information about an individual's past, present, or future physical or mental health that is maintained or transmitted by a healthcare provider or health plan. PHI includes, but is not limited to, medical records, symptoms, diagnoses, treatments, prognosis, lab results, medications, and information about insurance, claims, and payment.

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 healthcare 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 12 months after I am released from my mission, unless revoked in writing before that time. I may revoke this authorization by writing to DMBA, Attention: Missionary Medical Department, P.O. Box 45730, Salt Lake City, Utah 84145. Revocation becomes effective only after it is received by DMBA and the revocation will not apply to use and/or disclosure of PHI that occurs before the written revocation is received by DMBA.

Signature: I certify the above information is true and complete. I have a right to receive a copy of this authorization. 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: _____

(CONTINUED ON THE NEXT PAGE)

MISSIONARY
MEDICAL

Authorization to Use and/or Disclose Psychotherapy Notes

Name of Individual Whose Information Will Be Released

Name:_____ DMBA ID or Birth date: _____

Who Can Release Information: The Church of Jesus Christ of Latter-day Saints and its affiliated entities, including Deseret Mutual Benefit Administrators (DMBA), DMBA's business associates, and any and all healthcare providers and/or facilities (including mental health professionals) who have treated me before or after this authorization.

Who Can Receive Information

1. DMBA, including its Missionary Medical Department
2. Representatives and employees of the Missionary Department and the Risk Management Division 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. This includes historic site presidents, temple presidents, and visitors' center directors and their spouses
5. Individuals serving on the Mission Health Council
6. My home unit priesthood leaders (such as bishop and stake president) and clerks who may help my local priesthood leaders (such as ward and stake clerks)
7. Missionary Training Center personnel
8. BYU Student Health Center personnel
9. My parents or guardians as indicated below (if a box is not checked, "yes" is assumed):

   ❑ Yes ❑ No Name: _____ Relationship:_____ Birth date: _____

   ❑ Yes ❑ No Name: _____ Relationship:_____ Birth date: _____
10. Others I designate at my discretion as follows:

    Name: _____ Relationship:_____ Birth date: _____

    Name: _____ Relationship:_____ Birth date: _____

Information to Be Released: My psychotherapy notes, including notes recorded in any medium by a mental health professional that document or analyze conversations from private, group, joint, or family counseling sessions and that are separated from the rest of my medical record.

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 healthcare 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 12 months after I am released from my mission, unless revoked in writing before that time. I may revoke this authorization by writing to DMBA, Attention: Missionary Medical Department, P.O. Box 45730, Salt Lake City, Utah 84145. Revocation becomes effective only after it is received by DMBA and the revocation will not apply to use and/or disclosure of PHI that occurs before the written revocation is received by DMBA.

Signature: I certify the above information is true and complete. I have a right to receive a copy of this authorization. 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: _____