Metro Area Public Transit Systems
123 S Main Street
Joplin, Missouri 64801

AUTHORIZATION FOR USE OR RELEASE OF INFORMATION

To: _____(Insert name of Physician or Provide) I hereby authorize the use or disclosure of my individually identifiable health information ("Protected Health Information") as described below in this form (this "Authorization) to Metro Area Public Transit Systems MAPS/Sunshine Lamp Trolley – City of Joplin for purposes of determining my eligibility to receive ADA Para Transit transportation services.

Patient's Name: PRINTED _____ Today's Date: _____

Please send requested information to:
City of Joplin Transit Division, MAPS- Sunshine Trolley 123 S. Main, Joplin, MO 64801

Specific description of Protected Health Information to be used or disclosed:

Our applicant's, your patient's documented disability (ies) and how it (they affect his/her ability to independently use MAPS- ParaTransit otherwise accessible buses.

Event after which this Authorization expires:

Professional verification of specific information being requested (SEE ABOVE) which allows us to make an ADA Paratransit eligibility determination.

I understand that my Protected Health Information is subject to re-disclosure to the authorized recipient of the Protected Health Information pursuant to this Authorization and that the released Protected Health Information may no longer be protected by Federal Privacy regulations. I also understand that I may revoke this Authorization at any time by notifying you in writing, but if I do, it will not have any effect on my actions you took before you received the revocation of this Authorization.

_____ _____
Signature of individual or individual's representative Date

(FORM MUST BE COMPLETED BEFORE SIGNING)

If applicable, printed name of individual's representative: _____

Relationship to Individual: _____

Witness: _____ _____
Date