STATE OF MISSOURI
DEPARTMENT OF HEALTH AND SENIOR SERVICES

# AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

I, ____________________________________________ (name of designated contact) authorize and request the Department of Health and Senior Services to disclose/release the below specified information of:

| LICENSEE ENTITY NAME: | LICENSEE #: |
|---|---|
| EMAIL ADDRESS | PHONE #: |

TO: (NAME, ADDRESS, EMAIL, AND PHONE NUMBER OF BANKING INSTITUTION OR STATE/FEDERAL SUPERVISORY AGENCY AND INDIVIDUAL TO CONTACT)

THE SPECIFIC INFORMATION TO BE DISCLOSED IS: (CHECK ALL THAT APPLY)

☐ Application (specify application ID number) ____________________________________________

☐ License (specify state license number)____________________________________________

☐ Other regulatory or financial information (specify with description, file name, and date submitted to the Department)

This disclosure is pursuant to §362.034, RSMo, and is reasonably necessary to facilitate the provision of financial services to the entity identified herein. By requesting this disclosure, I, on behalf of the Licensee, hereby waive the Department's duty of confidentiality or privilege that applies to the information specified herein with respect to the disclosure of such information to the institution or agency identified above. This waiver does not constitute a complete waiver of confidentiality.

| NAME OF LICENSEE DESIGNATED CONTACT | |
|---|---|
| SIGNATURE OF LICENSEE DESIGNATED CONTACT | DATE |