



# AUTHORIZATION OF DISCLOSURE - Medical/Dental

Client Name: \_\_\_\_\_ Client #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I authorize Compass Health Network to:  Disclose To \_\_\_\_\_ Last Four SSN \_\_\_\_\_

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

Address: \_\_\_\_\_

The following information relative to treatment received from: \_\_\_\_\_ to: \_\_\_\_\_

### Information to be Disclosed:

- Entire Record
- Physician Notes
- Immunizations
- Well Visits
- Questionnaire Form
- Date of Service Note: \_\_\_\_\_
- Laboratory and X-Ray Results
- Medication List
- Other \_\_\_\_\_

### Purpose of Disclosure:

- At Patient's Request
- To assure coordination of treatment
- To assist in my treatment
- Aftercare
- Other (specify): \_\_\_\_\_

This authorization becomes effective on \_\_\_\_\_ and will automatically expire one year from the date of request or sooner as designated. Please specify: \_\_\_\_\_

I understand that I have a right to revoke this authorization at any time. I must do so in writing and present my written revocation at the office where I am being seen. I further understand that actions already taken based on this authorization, prior to the revocation, will not be affected.

I understand that I have the right to a copy of this authorization.

I understand that authorizing the disclosure of this protected health information is voluntary in most cases. I can refuse to sign this authorization. I will be refused treatment for my refusal to sign if my care is mandatory by Corrections or the Juvenile Justice System. I understand that I may request to inspect or obtain a copy of my record. I understand that any disclosure of information carries the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my protected health information, I can contact the Privacy Officer for Compass Health Network.

My signature below acknowledges that I have read, understand and authorize the release of my protected health information.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Legal Guardian/Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date