AUTHORIZATION OF DISCLOSURE - Medical/Dental

Client Name: _____ Client #: _____ Date of Birth: _____

I authorize Compass Health Network to: ☐Receive From 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