Compass Health Network

AUTHORIZATION OF DISCLOSURE OF PROTECTED HEALTH INFORMATION – Medical/Dental

Patient's Name: _____ Date of Birth: _____

Last 4 Digits of Social Security #: _____ Client #: _____

I authorize Compass Health Network to: ☐ Disclose To ☐ Receive From

Name: _____

Address: _____

City: _____State: _____ Zip:_____ Fax: _____

Date of Services for PHI to be Released:

From (date): _____ To (date):_____

Information to be Disclosed: *(check all that apply)*

☐ Entire Record ☐ Physician Notes ☐ Immunizations ☐ Well Visits

☐ Questionnaire From ☐ Laboratory & X-Ray Results ☐ Medication List

☐ Date of Service Note: _____ ☐ Other: _____

Purpose of Request: *(must check one)*

☐ At patient's request ☐ To assist in my treatment ☐ Aftercare

☐ To assure coordination of treatment ☐ Other: _____

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