COMPASS HEALTH

RELEASE OF INFORMATION FORM

Medical Record Number: _____ **Date of Birth:** _____ **SS#:** _____

Type of Request/Disclosure: ☐ Medical Record(s) ☐ Letter/Form/Report ☐ Verbal Communication

I _____ hereby give my permission to Compass Health Systems, PA or to
Name of Patient (Please Print)
the entity listed below to release information contained in my medical record. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, sexual abuse treatment, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions, and that under *Federal* Law these records are classified as privileged and confidential and cannot be released to me or those designated by me or my legal guardian without expressed and informed consent. In addition, I understand that those records will not be released to entities other than those designated by myself or my personal representative or otherwise provided in federal law.

Release/Request Medical Information to:

Name of Recipient/Requestor: _____ Telephone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Reason for Request/Disclosure: _____

_____

I authorize Compass Health Systems, PA to request/disclose the health information **covering the treatment dates of**: _____

The type of information to be requested/ disclosed is as follows:

To Be Released	**To Be Requested**
☐ Treatment Plans	☐ Treatment Plans
☐ Psychiatric Progress Notes	☐ Psychiatric Progress Notes
☐ Health/Medical Records	☐ Health/Medical Records
☐ Education Reports	☐ Education Reports
☐ Discharge Summaries	☐ Discharge Summaries
☐ Psychological/Psychiatric Evaluations	☐ Psychological/Psychiatric Evaluations
☐ Social/Development History	☐ Social/Development History
☐ Verbal Communication	☐ Verbal Communication
☐ Other: _____	☐ Other: _____

_____ (initial) I understand that I have the right to withdraw my authorization at any time, except to the extent that action has already been taken pursuant to the authorization. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Records Department.

_____ (initial) I understand that authorizing to disclose this health information is voluntary, I can refuse to sign and Compass Health Systems, PA will not base my treatment, payment or eligibility for benefits on whether or not I provide authorization for the requested use or disclosure. I understand that I may inspect or copy the information to be disclosed as provided in CFR164.524 (with reasonable charge)

_____ (initial) I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information is no longer protected by federal confidentiality laws or Compass Health Systems, PA.

_____ (initial) I understand that Compass Health Systems will release only the minimum amount of information to satisfy a request and will not release any records whereby the disclosure may result in harm or injury to myself or others.

_____ (initial) I acknowledge that a fee of no less than $25 will be assessed to me for the completion of any letter or form by Compass Health Systems. I understand that the fee may be greater than $25 depending on the length and complexity of the requested information.

_____ (initial) I understand that Compass Health Systems will release protected electronic health information (ePHI) when it is requested in that format.

This authorization will expire one year from the date of signing and is subject to revocation with writing at any time. Expiration Date: _____

Requested by: _____

Pick Up: _____ Fax:_____ Mail: _____

Address: _____

Paid: $_____ PREPARED BY:_____

Patient/Representative Signature:_____ Date: _____

Relationship to Patient Representative: _____