COMPASS
HEALTH CENTER

INSTRUCTIONS ON COMPLETING THE AUTHORIZATION TO RELEASE INFORMATION

Please note that all highlighted fields must be completed for records to be sent.

For the section on who information is to be shared with please **include the fax number if that is the preferred method for sharing records OR the email address if encrypted email is the preferred way of receiving records**.

For the section of how information is to be shared please choose **ONE** of the three options for the way in which records will be shared:

1. **Both Verbal and Written Communication** (this will allow for verbal communication and records to be sent);
2. **Verbal Communication** (this will only allow Compass to verbally share information)
3. **Written Communication** (this will only allow Compass to deliver written/digital communication)

Then choose **ONE** of the two following options for what material in the record will be shared:

1. **Entire Record**
2. **Limited to Areas Checked Below** -- If this is chosen, please be certain to check the appropriate boxes for information that **WILL** be shared with the individual/agency

Covering the Periods of Healthcare

This is the period health care that you want records released from and to, i.e. when you started and completed program. An estimate of the dates is fine, i.e. From: 1/1/2023 To: 1/1/2024

Expiration Date

A calendar date must be entered as an expiration date for the authorization to be valid. If you fail to enter a date here, a date of one year following the date the release has been signed will be entered for you.

Signature Requirements

a. If the patient is 12 – 17 years old, they must sign the form

b. If the patient is 12 -17 years old, the parent must also sign the form

c. If the patient is 18+ years old, the patient must sign the form

d. For ALL releases, regardless of age of the patient, a witness 18+ years must sign the form

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RELEASE OF INFORMATION

A separate form is required for each individual/entity

This form allows Compass Health Center to speak to and share information with the individual/entity listed below about your treatment.

I hereby authorize Compass Health Center, PLLC / Compass Health Center Chicago, PLLC / Compass Health Center Oakbrook, PLLC / Compass Health Center Virtual, PLLC / Compass Health Center Maryland, LLC / Compass Health Center Virginia, LLC / Compass Health Center DC, PLLC / Compass Health Center Wisconsin, LLC / Compass Psychiatry Group, PLLC and all employees, agents, and designees (collectively "Compass Health Center") to use, release, disclose, receive and/or exchange mental health and medical information concerning:

_____

Name of Patient (Print) **Date of Birth**

This information will be disclosed to and/or exchanged with:

Name/School/Agency: _____ **Confidential Phone:** _____

Address: _____

Fax: _____ **Email:** _____

Relation to the Patient is: ☐ Parent ☐ Psychiatrist ☐ Therapist ☐ Social Worker ☐ Primary Care Physician
☐School ☐Self ☐Other: _____

The purpose for which the information may be disclosed is:

☐Continuing Care ☐Personal ☐Education Planning ☐Insurance/FMLA/Disability Eligibility
☐Legal ☐Other (*describe*): _____

I understand that, unless otherwise noted below, this authorization extends to all or any part of the records/information designated below, which may include treatment for physical and mental illness, substance use disorder, sexually transmitted disease, HIV/AIDS test results or diagnoses, and Protected Health Information.

I authorize the information to be disclosed through:

☐Both Verbal and Written Communication ☐ Verbal Communication ☐Written Communication

☐ ***Entire Record*** **OR** ☐ ***Limited to Areas Checked Below:***

- ☐ AIDS/HIV Status
- ☐ Biometric Data (height/weight/vitals)
- ☐ Diagnoses
- ☐ Discharge Summary
- ☐ Educational Assessments
- ☐ Family Therapy Notes
- ☐ FMLA/Disability Paperwork
- ☐ Genetic Test Results
- ☐ Group Therapy Notes
- ☐ Insurance/Billing Information
- ☐ Intake Evaluation(s)
- ☐ Lab work/EKG/Diagnostic Imaging
- ☐ Medication
- ☐ Medication History
- ☐ Participation in Program
- ☐ Progress Notes
- ☐ Psychiatric Evaluation(s)
- ☐ Safety Plan(s)
- ☐ Substance Use Disorder Records
- ☐ Substance Use Test Results
- ☐ Treatment Plan(s)
- ☐ Treatment Summary

☐Other: _____

Covering the Periods of Health Care: From (date): _____ To (date): _____

This authorization is limited to only that information described above.

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RECITALS:

1. **Expiration:** This authorization is valid until _____. **If no calendar date is entered, this authorization will expire on the specific calendar date one year from the date of signature below, except to the extent a longer term of validity is required by applicable law.**
2. **Required or Permitted by Law:** I/we understand that Compass Health Center's ability to use or disclose Protected Health Information without consent to the extent permitted or required by applicable law is not impacted by my/our decision to authorize, not authorize or revoke this authorization.
3. **Redisclosure:** I/we understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be used or redisclosed by the receiving party, pursuant to any agreement I/we may have with such party. However, if the information disclosed constitutes substance use disorder records subject to federal confidentiality protections, 42 CFR Part 2 prohibits unauthorized disclosure of these records.
4. **Refusal to sign:** I/we understand that I/we may refuse to sign this authorization and the result would be that the records would not be disclosed. I/we understand that Compass Health Center generally may not condition services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.
5. **Revocation:** I/we have the right to stop the use or release of this information at any time if I/we do so in writing; although I/we understand that such revocation will not apply to information already used or disclosed pursuant to this authorization.
6. **Copy Received:** I/we understand that I/we will receive a copy of this completed form.
7. **Inspect & Copy:** I/we understand that I/we have the right to inspect and copy the information to be disclosed.
8. **Amendment:** I/we understand that I/we have the right to request amendment of any information contained in the subject file.
9. **Effect of Copies:** I/we intend that mailed disc, fax, copies or electronic versions of this document shall carry the same force and effect as the original.

Certification:
The undersigned affirms that I am (check whichever applies):

- ☐ The patient, and the identification that I have provided is true and correct.
- ☐ The patient's authorized representative, and that the identification and proof of authority that I/we have provided are true and correct. My relationship to the patient is that of: (check one) ☐Parent, Guardian, ☐Other _____.

I acknowledge and understand that by signing below I authorize the transmission of this information via verbal, facsimile, electronic or disc sent via USPS mail to the party indicated above and understand the limits of confidentiality as a result of such transmission.

Date	**Patient Signature (Required if *12 years or older*)**	**Printed Name**
Date	**Parent/Guardian/Other Authorized Agent Signature (*if applicable*)**	**Printed Name**
Date	**Witness to Patient/Parent/Guardian/Agent Signature**	**Printed Name**