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 Health Center Minnesota, LLC / Compass Psychiatry Group, PLLC / Compass Psychiatry Group Wisconsin, LP 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
☐ Psychiatric Evaluation(s)
☐ Psychiatric Progress Notes
☐ Therapists Progress Notes
☐ Safety Plan(s)
☐ Substance Use Disorder Records
☐ Substance Use Test Results
☐ Treatment Plan(s)
☐ Treatment Summary
☐ Transcranial Magnetic Stimulation Therapy

☐Other:____

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

Updated: 3.10.2026

This authorization is limited to only that information described above.

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**	**Printed Name**
____________________	____	___________________________
Date	**Parent/Guardian/Other Authorized Agent Signature** (***if applicable)***	**Printed Name**
____________________	____	
Date Reviewed/Signed	**Staff Signature**	

Updated: 3.10.2026