COMPASS HEALTH

SETTING A NEW DIRECTION IN HEALTH CARE

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information from my medical record as described below. This may include **medical**, **psychological, neuro-psychological, psychiatric, HIV/AIDS test results or diagnoses, drug and/or alcohol abuse** information.
I understand that this authorization is voluntary.

Patient Name:		**Today's Date**:
Date of birth:		**Phone Number**:
Mailing Address:		
Street	City/ Town	State Zip Code

Description of information that may be disclosed:

☐ Emergency Room Record
☐ Inpatient Record
☐ Outpatient Record
☐ Other _____

Date(s) of service: _____

Medical Record Number _____

If the requested portion of the record contains information related to drug/alcohol, mental health or HIV related information, you must specifically consent to the release of such information by initialing here_____(must initial)

Organization Providing the Information:

Compass Heath
Attn: Medical Records
2175 Coolidge Rd.
East Lansing MI, 48823
Phone: 517-999-5900
Fax: 517-999-5901

Persons/Organization Receiving the Information

_____
Name
_____
Street Address
_____
City State Zip Phone/Fax

1. The information will be used/disclosed for the following purposes: _____
2. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by Federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.
3. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may see or copy the information used/disclosed under this authorization and that I can get a copy of this form after I sign it.
4. I understand that I may revoke this authorization in writing at any time by notifying the providing organization in writing, but if I do it won't affect any actions they took before they received the revocation.
5. I understand this authorization expires on____/___/____.

IF DATE IS NOT STATED, THE AUTHORIZATION WILL EXPIRE IN ONE YEAR.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Printed name of Patient or Personal Representative Relationship to Patient