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.

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:

Any and all radiology films done between the dates of ________________ and ____________________.

Any and all medical records.

Organization Receiving the Information:

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

Persons/Organization Providing the Information

Any and all radiology department(s)
Medical physicians

1. The information will be used/disclosed for the following purposes: Comparison of Films and Continuing Care
2. 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.
3. 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.

This authorization will remain valid and will indefinitely authorize the release of information related to my care at Compass Health Cancer Center.

______________________________ Signature of Patient or Personal Representative

______________________________ Date

______________________________ Printed name of Patient or Personal Representative

______________________________ Relationship to Patient