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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Name: _____
Last First MI Previous Name

_____ _____
Birth Date Phone

Address: _____
Street City State Zip

The individual has the right to restrict the disclosure of any of the types of information.

I authorize disclosure of my medical, psychiatric, mental health, and substance abuse information

____**TO:** Compass Rose Counseling and Wellness, LLC and/or ____ **FROM:** Compass Rose Counseling and Wellness, LLC

____**TO:** and/or ____ **FROM:** (Agency or individual name)_____
(Address & Phone #)_____

The following information may be disclosed: (Pertinent, minimum necessary to accomplish the stated purpose)

_____Medical History / lab results
_____Diagnostic assessment, Psychiatric Evaluation
_____Treatment Plan
_____Progress notes
_____Discharge / Termination Summary
_____Social Service Reports / Interventions
_____School Reports: Grades / Behavior Reports
_____Evaluation / Testing results
_____Other:_____

_____ I agree that information that may be disclosed may include AIDS / HIV infection.

The Purpose of this disclosure is for:

_____Continuing care / treatment planning
_____Litigation
_____Social Services involvement
_____Other:_____
_____Personal Records

I understand this is a valid lifetime authorization while actively participating in therapy or for a shorter time period I specify.
I may withdraw this authorization at any time by notifying in writing the agency disclosing the information.
Information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer protected by HIPPA.
I understand I have the right to inspect or copy (for reasonable cost) the information I have authorized to be disclosed.
I have a right to a photocopy of this signed authorization.
A photocopy of this authorization shall be valid with Signature and Date* written by the authorized individual.

* _____ * _____
Signature of client or Legal Representative Date signed

* _____
Relationship to client

Revised 12/5/24