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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Client Name: _____

Date of Birth: _____ Phone: _____ Previous Name: _____

Address: _____

I authorize Compass Rose Counseling and Wellness, LLC and the person/organization listed below to disclose and/or receive the protected health information specified in this authorization.

PERSON / ORGANIZATION: _____

Address / Phone / Fax: _____

Direction of disclosure: ☐ TO Compass Rose ☐ FROM Compass Rose ☐ TWO-WAY EXCHANGE

INFORMATION AUTHORIZED FOR DISCLOSURE

Please check only the information needed for the stated purpose:

- | | |
|---|---|
| ☐ Diagnostic assessment / psychiatric evaluation | ☐ Evaluation / testing results |
| ☐ Treatment plan | ☐ Social service reports / interventions |
| ☐ Progress notes | ☐ School reports / grades / behavior reports |
| ☐ Discharge / termination summary | ☐ Substance use information / records* |
| ☐ Medical history / laboratory results | ☐ Other: _____ |

*Some specially protected records may require additional or more specific authorization before disclosure.

☐ I specifically authorize disclosure of HIV/AIDS-related information, if contained in the records selected above.

PURPOSE OF DISCLOSURE

- ☐ Continuing care / treatment planning ☐ Social services involvement ☐ Personal records
☐ School coordination ☐ Work / leave / accommodation ☐ Legal / litigation
☐ Other: _____

EXPIRATION

This authorization expires on: _____ OR upon this event: _____

If no date/event is written, this authorization will expire one year from the date signed, unless otherwise required by law.

YOUR RIGHTS AND ACKNOWLEDGMENT

I understand that I may revoke this authorization at any time by providing written notice to Compass Rose Counseling and Wellness, LLC, except to the extent that action has already been taken in reliance on it.

I understand that information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy rules, except where other laws continue to protect it.

I understand that signing this authorization is voluntary and that treatment, payment, enrollment, or eligibility for benefits generally will not be conditioned on signing this authorization.

I understand that I may request a copy of this signed authorization and may inspect or obtain a copy of information as permitted by applicable law.

Client / Legal Representative Signature

Date

Printed Name of Legal Representative (if applicable)

Relationship to Client