COMPASS Health

RELEASE OF INFORMATION

Client Name/ID/DOB *(or affix label)*	Previous/Maiden Name or Alias:
_____	_____

COMPASS HEALTH

Address: _____

_____

Phone: _____

Fax: _____

Attn: _____

Compass Health may ☐ Disclose ☐ Receive ☐ Exchange the protected health information indicated below with:

Person or Facility: _____

Address: _____

_____

Phone: _____

Fax: _____

I authorize the release of **any and all of the following medical, mental health and/or substance use disorder information, as specified,** which may be contained in my records (Check all that apply)with the following date parameters:
☐ All Dates - or - Date Range: _____

☐ Behavioral Health Diagnoses	☐ Progress Notes	☐ Medical History/Profile
☐ Mental Health Assessment	☐ Listing of Services Provided	☐ Lab Results
☐ Psychiatric Evaluations	☐ Compliance Reports	☐ Drug Screen Results
☐ Substance Use Disorder Assessments	☐ Medication Summary	☐ Substance Use Abstinence Status
☐ Treatment/Crisis Plans	☐ Nursing Assessments	☐ Attendance Records
☐ Treatment Plan Reviews	☐ History and Physical	☐ Discharge Summary
☐ Psychiatric Treatment Notes	☐ Medical Diagnoses	☐ Other (specify): _____

Purpose of this Disclosure: (check all that apply)

☐ Assisting in diagnosis and treatment	☐ Verify compliance
☐ Assuring continuity of care	☐ Legal Consulting
☐ Treatment planning	☐ Determine disability
☐ Coordinating care/service delivery	☐ Vocational
☐ Report on progress	☐ At the request of the individual
☐ Referral for other treatment	☐ Educating natural supports about behavioral health issues
☐ Inform others of treatment status	☐ Other (specify): _____

I understand that my record may contain information regarding testing, diagnosis, or treatment of HIV/AIDS, or of sexually transmitted diseases. I give my specific authorization for these records to be disclosed. (RCW 70.24.105)	☐ Approve ☐ Deny

As the individual signing, I understand the terms of this Authorization, including:

1. I am giving my permission to Compass Health to disclose my confidential health records.

2. That my signing of this Authorization is voluntary.

3. My health information is protected by federal HIPAA Privacy regulations.

4. If the organization authorized to receive the Information is not a health plan, healthcare clearing house or health care provider covered by federal privacy regulations, the released Information may no longer be protected from further use or disclosure by federal privacy regulations and may be subject to re-disclosure by the recipient(s).

5. Staff of Compass Health may not condition treatment, payment, or enrollment on the signing of this Authorization.

6. A photocopy of this Authorization is as valid as the original, and that I am entitled to a copy of this Authorization. Compass Health reserves the right to utilize any and all secure methods for releasing the information specified above.

7. Paper or electronic copies of my records may be used to facilitate disclosure of my information.

8. I understand that I may see and receive a copy of the Information described on this Authorization if I request it in writing.

9. I understand that I have the right to refuse to sign this Authorization.

10. I may revoke this consent at any time by signing and dating a formal request, except to the extent that action has already been taken in reliance upon it.

This Authorization is effective (date): _____

Unless revoked earlier by me, this authorization shall expire either 30 days after the signature date, or upon discharge from services at Compass Health, whichever is *later*.

NOTICE: Information approved for disclosure based on this authorization may be protected by Federal Regulations (42 CFR Part 2), which prohibit a recipient from making any further disclosure of alcohol or substance abuse treatment information unless expressly permitted by written authorization of the person to whom it pertains or their legal representative or otherwise permitted by 42 CFR Part 2. These Federal Regulations also restrict any use of the information to criminally investigate or prosecute any substance use disorder client. 42 CFR Part 2 permits only limited disclosures regarding deceased clients when required by federal or state laws for the collection of vital statistics or an investigation into the cause of death.

_____ _____

Signature of client, or client's parent/guardian/legal representative Date

☐ (*Office Use Only*) Document was provided to the client in an alternative language