RELEASE OF INFORMATION

Client Name/ID/DOB *(or affix label)*	Previous/Maiden Name or Alias:
Jonathon Smith 01/01/2001 **Chosen Name:** Jon Smith	

COMPASS HEALTH

Health Information Management
Phone: 425-349-8386
Fax: 425-349-8290

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

Person or Facility: Dr. Nancy Williams
Relationship Type: PCP
Address: 123 Main Street, Everett, WA 98201
Phone: 425-123-4567
Fax: 425-123-6789
Email: pcpoffice@gmail.com

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	☐ Lab Results
☑ Mental Health Assessment	☐ Listing of Services Provided	☐ Drug Screen Results
☑ Psychiatric Evaluations	☐ Compliance Reports	☐ Substance Use Abstinence Status
☐ Substance Use Disorder Assessments	☐ Medication Summary	☐ Attendance Records
☐ Treatment/Crisis Plans	☐ Nursing Assessments	☐ Discharge Summary
☐ Treatment Plan Reviews	☐ History and Physical	☐ WISe Child & Family Team Meeting Minutes
☐ Psychiatric Treatment Notes	☐ Medical Diagnoses	☐ WISe Cross System Care Plan
	☐ Medical History/Profile	☐ Other (specify):_____

Purpose of this Disclosure: (check all that apply)

☑ Assisting in diagnosis and treatment	☐ Verify compliance
☑ Assuring continuity of care	☐ Legal consult/hearing
☑ 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):_____

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 as specified above.

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. My substance use disorder treatment record (or information contained in the record) may be redisclosed in accordance with the permissions contained in the HIPAA regulations, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against the me.

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

7. 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.

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

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

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

11. I may revoke this consent at any time by verbal request or 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 on the date of signature.

Unless revoked earlier by me, this authorization shall expire:
☐Upon Discharge from services at Compass Health
☑Other Date: 01/01/2027
NOTICE: If the information released under this authorization was produced by a Compass Health Substance Use Disorder Treatment Program, 42 CFR part 2 prohibits unauthorized use or disclosure of these records.

The individual signing this release is:
☑ The client
☐ The client's parent
☐ The client's legal guardian*
☐ Other individual with rights to consent to behavioral health treatment: _____
☐ If applicable, I have provided documentation of my right to sign this document on behalf of the client (e.g. Guardianship paperwork, court order, etc.)
*If signed by a legal guardian, Compass Health must have a copy of guardianship paperwork.

Jon Smith Digitally signed by Jon Smith DN: cn=Jon Smith gn=Jon Smith c=US United States l=US United States Reason: example client Location: Date: 2026-07-01 10:49-07:00 Date: 07/01/2026

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

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