

Authorization to Release Health Information

Name of Patient:	Patient's Date of Birth:	Medical Record Number:
Full Address:	Patient's phone #:	

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires us to obtain your authorization to use or disclose your healthcare information for any purpose not otherwise permitted by HIPAA. Please complete the information below if you wish to provide this authorization for the use or disclosure of your healthcare information.

1) I, _____, hereby authorize Compassus and its affiliates (the "Company") to release or disclose information regarding the patient identified above. I authorize the use or disclosure of this information to the following recipients (this must tell to whom and where the information can be released):

2) My healthcare information may be used and disclosed for the following purpose(s) *This is a required field:

My name and date of death if for a memorial event

Other (ie. Insurance, Continuity of Care, Personal Use): _____

3) I authorize the use and disclosure of the information as indicated below:

My entire Medical Record **from Company**. I understand this may include diagnosis information, HIV/AIDS or mental health status, information about how I feel, records of treatment received, laboratory test results, appointments, and any other medical-related information about me held by Company. This information may indicate that I have a medical condition, including mental health conditions, HIV/AIDS or have used drugs or alcohol.

Only the following records **from Company** (please check all that apply)

Discharge Summary/ Summary of treatment

Progress Notes

Lab Results, including x-rays or other imaging

Photographs, videos, or other images

History and Physical exam (H&P)

Consultation Reports

HIV/AIDS test results and treatment information

Alcohol/ Substance Use Treatment/ Referral

Mental Health (does not include psychotherapy notes)

Other (specify):

4) This authorization will expire one (1) year from the date of my signature, unless a different date or expiration event is indicated below:

Specify new date of expiration _____

5) I have the right to revoke this authorization at any time by notifying the Company at **10 Cadillac Dr, Ste 400, Brentwood TN, 37027 Attn: Privacy Officer**. My revocation of this authorization must be in writing. My revocation will not be effective to the extent the Company has already relied upon this authorization (by using or disclosing information).

6) The Company is subject to HIPAA and may only use and disclose information received as a result of this form as permitted by the HIPAA privacy rules and state law. If received by entities not covered by HIPAA, the information disclosed as a result of this authorization may no longer be protected by the federal HIPAA privacy rules. I understand I may obtain a copy of this form by contacting the Privacy Officer at the address listed above.

7) I understand that signing this authorization is optional. I may choose not to sign this form. I understand that the Company will not condition my treatment or payment for care on whether I sign this authorization.

SIGNATURE OF PATIENT OR REPRESENTATIVE:	DATE:
RELATIONSHIP TO PATIENT, IF SIGNED BY REPRESENTATIVE:	DATE: