

Authorization for Release –Compass Clinic- Dr. Ira J. Goodman and Dr. Sheila Baez-Torres

Patient Name: _____

SS#: _____ DOB: ____/____/____

Street or PO Box: _____

City, State, Zip: _____

Phone Number (Day): _____ Phone Number (Evening): _____

I, _____, hereby authorize **The Compass Clinic** to release my PHI as follows:

Release to: Via Fax Via Mail _____

Disclosure Purpose: For treatment at the request of the patient.

Disclosure Description: Billing Lab Reports X-rays History

Shot Records Only Radiology Reports Pathology Reports Entire Record

Other (Describe): _____

_____ for records dated from: _____ to: _____

I understand that:

- Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- The statements included in this Authorization are binding on the Provider.
- The use or disclosure requested under this Authorization ____will ____ will not result in direct or indirect remuneration to the Provider from a third party.

I understand that I have the right to:

- Revoke this Authorization, in writing, at any time by sending such written notification to the Provider. I also understand that such a revocation will not have any effect on any information already used or disclosed by the Provider before the Provider received my written notice of revocation.
 - Inspect or copy the protected health information to be used or disclosed as permitted under federal law or state law to the extent the state law provides greater access rights.
 - My revocation of this Authorization will not affect my ability to obtain treatment, receive payment or eligibility for benefits unless allowed by law.
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This authorization will expire in one hundred eighty days (180): _____ (Date)

Name of Patient or Personal Representative*

Signature of Patient or Personal Representative*

Relationship of Patient or Personal Representative*

Date

Personal Representative may be required to provide verification or representative status. *