Authorization for Use or Disclosure – The Compass Clinic- Dr. Ira J. Goodman M.D.

Attention Health Care Provider:

Please provide the medical records requested by The Compass Clinic as authorized by the patient listed below**.**

Patient Name: _____

SS#: _____ DOB:_____/_____/_____

Street or PO Box: _____

City, State, Zip: _____

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

I, _____, hereby authorize _____ to Use and/or disclose my PHI as follows:

Disclose to: ☐ Via Fax ☐ Via Mail

The Compass Clinic
100 W. Gore Street, Suite 406
Orlando, Florida 32807
Phone: 407-210-1320 Fax: 321-202-2582

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.

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. *