A Compass Within Personal Consulting

Authorization for Release of Protected Health Information

Client's Name: ____

Address: __________________________________ City: _________________ State: _____ Zip:________

Phone: ___________________________ DOB: ______________________

I, ____________________________________, request and authorize A Compass Within Personal Consulting to release the information indicated below to:

Name: ____

Address: __________________________________ City: _________________ State: _____ Zip:________

Phone: ___________________________ Fax: ______________________

Specific information to be disclosed:

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The above information will be used for the following purposes:

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Duration of Authorization: I understand that this authorization is valid only for the purpose, information, agencies, and persons cited above. Unless otherwise revoked, this authorization will **expire in one year**.

Re-disclosure: I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I understand that my Protected Health Information (PHI) that is used or disclosed under this authorization may be subject to re-disclosure by the recipient, and the privacy of my PHI may no longer be protected under these guidelines if they are not a health care provider covered by state or federal rules. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

Revocation of Authorization: I understand that this authorization is voluntary and may be revoked in writing at any time, except to the extent that A Compass Within Personal Consulting has already taken action upon it. I understand that if I revoke this authorization, I must do so in writing. A Compass Within Personal Consulting will not condition treatment or payment based on this authorization or revocation of the authorization unless otherwise allowed by law.

Client's Signature: ____ Date: _____________

Witness' Signature: ____ Date: _____________