COMPASS MEDICAL

Exceptional Medicine. Compassionate Care.

Authorization to Use & Disclose Protected Health Information

Patient Information

Patient Name (Please Print):______________________________ Date of Birth: ______________________

Any other Previous Names: ______________________________

Patient Address:______________________________ Phone #'s:______________________

City:____________ State:________ Zip:____________ EMAIL: ______________________

Your Compass Medical Doctor's Name that you are requesting records from: ______________________

I hereby Authorize Compass Medical to:

Please choose one: ◯ Release my medical record information to ◯ Obtain medical information from

Name/Facility:______________________________ Attention:______________________

Address:______________________________ Phone #: ______________________

City:____________ State:________ Zip:____________ Fax #: ______________________

Purpose of Request: ◯ Personal ◯ Referral or 2nd Opinion ◯ Legal ◯ Insurance ◯ Other______________

◯ Transfer from Practice/Reason? ______________________________.

Specific Records/Report(s) to be released:

◯ Provide a 2-year abstract of my records.

◯ Provide a copy of my full electronic record.

◯ Other - be specific, include dates and MD's under comments.

******Please do not prepay. You will be invoiced for your selection by our vendor. ******

**COPY FEE: For Patient record requests – Pursuant to HIPAA 45 CFR, 164.524, we reserve the right to charge a reasonable cost-based fee for producing and mailing the copies. If you wan the entire medical record or more than the two-year abstract, the rate will increase proportionately based on the cost. For all other release of information requests, the Massachusetts Chapter 111, Section 70 guidance will be followed.*

Restricted Authorization to Release Protected Information:

IMPORTANT - It is extremely important that you select either you "**DO**" or "**DO NOT**" for each item contained in this section *Authorization to Release Protected Information.* Please do not skip any line item as it could impact our ability to fulfill your request and cause additional delays.

Release Records? Check one

I ☐ **DO** ☐ **DO NOT** want **Mental/Behavior Health or Disability Services Provider Documentation** * released**.**

I ☐ **DO** ☐ **DO NOT** want **HIV/AIDS Screening Test Results** released

I ☐ **DO** ☐ **DO NOT** want information about **Alcohol and/or Substance Abuse Treatment** *** released

I ☐ **DO** ☐ **DO NOT** want **Genetic Testing/Test Results** ** released

I ☐ **DO** ☐ **DO NOT** want **Confidential Communications with a Social Worker** released

I ☐ **DO** ☐ **DO NOT** want information about **Rape/Sexual Assault Victim's Counseling** released

I ☐ **DO** ☐ **DO NOT** want **Child/Elder Abuse or Neglect & Abuse of an Adult with a Disability** released

I ☐ **DO** ☐ **DO NOT** want information about **Sexually Transmitted Disease (STD's)** released

I ☐ **DO** ☐ **DO NOT** want information about **Domestic Violence Victim's Counseling** released

* This Authorization is not valid for use or disclosure of psychotherapy notes.

** The term "genetic tests" means only those tests which determine your future chances of developing a disease, not test done to diagnose a current condition or problem. This includes information related to the testing of embryo's created during IVF.

*** Only applicable to records that are created by an "individual or entity who holds itself out as providing alcohol or drug abuse diagnosis, treatment or referral for treatment" (42 CFR Part 2). Does not include records created or maintained by a general medical facility.

Sign Here Date Here

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Signature of Patient's **Date**

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Signature of Personal Representative **Date** **Relationship to patient or authority to act for patient**

Term: This Authorization will remain in effect until Compass Medical fulfills this request.

Revocation: I understand that I may revoke this Authorization at any time by requesting it of Compass Medical in writing at the address listed below. The revocation will be effective immediately upon Compass Medical's receipt of my written notice. I understand that the revocation will not have any effect on any action taken by Compass Medical in reliance on this Authorization before it received my written notice of revocation.
Written Notice is to be mailed to: Compliance Office, Compass Medical, P.C., 362 N. Bedford Street, East Bridgewater, MA 02333

Effect on Treatment: I understand that I may refuse to sign this Authorization for any reason and that such refusal will not affect the commencement, continuation or quality of my treatment at Compass Medical

Potential for Redisclosure: I understand that the person receiving my Protected Health Information may not be required to comply with federal and state Privacy laws, and my Protected Health Information may no longer be protected by the applicable state and federal law once it is disclosed by Compass Medical.

Access: I understand that in certain circumstances Compass Medical has the right to deny me access to all or portions of my Protected Health Information and must notify me in writing of any such denials.

Rev. 04/2022