COMPASS HOSPICE

Authorization to Release or Obtain Health Information

Patient Name: _____ **Date of Birth:** ____ / ____ / _____ **Address:** _____ **City/State/ZIP:** _____ **Phone:** _____	**For Office Use Only** Date Released: ____ / ____ / _____ Released By: _____ Method: ☐ Fax ☐ Mail ☐ Electronic ☐ In-person

1. Purpose of Release	2. Information to be Released
☐ Release information to ☐ Obtain information from ☐ Two-way exchange of information **Name/Organization:** _____ **Address:** _____ **City/State/ZIP:** _____ **Phone:** _____ Fax: _____ Purpose of release: ☐ Continuity of care ☐ Hospice admission ☐ Insurance ☐ Legal ☐ Other: _____	(Check all that apply) ☐ Complete medical record ☐ History & physical ☐ Physician orders ☐ Hospice plan of care ☐ Medication list ☐ Lab/test results ☐ Hospital records (dates): _____ ☐ Other: _____

3. Sensitive Information	4. Expiration & Revocation
This authorization includes the release of information related to: ☐ HIV/AIDS testing or treatment _____ ☐ Sexually transmitted diseases _____ ☐ Mental health/psychiatric care _____ ☐ Alcohol or drug abuse treatment _____ Initial each selected item	• This authorization expires on: ____ / ____ / _____ or **one year from the date signed** unless revoked earlier. • You may revoke this authorization at any time by providing written notice to: Compass Hospice, except to the extent that action has already been taken based on this authorization.

5. Patient Rights

- You may inspect or obtain a copy of the protected health information disclosed.
- Signing this authorization is voluntary. Your treatment will not be conditioned on signing unless required for participation in a research study or to create health information for a third party.
- Information disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.

Signature of Patient or Personal Representative: _____
Printed Name: _____
Relationship (if not patient): _____
Date: ____ / ____ / _____

Signature of Witness: _____
Date: ____ / ____ / _____