AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Compassion HealthCare

9015 Americana Rd Suite 8b

Vero Beach, FL 32966

Off (877) 277-1688 Fax (877) 338-5282

Zambellimedical@yahoo.com

Date: _____ Date of Birth: _____ SSN: _____

Patient Name: _____

Address: _____

I, the undersigned, do hereby grant permission for Compassion Health_____ obtain from or _____ release to

_____

Name of Institution information is coming from or going to

_____

Address of Institution information is coming from or going to

The following information from the patient's clinical record:

_____

_____

_____

I understand that this information will be used for the purpose of:

____ Providing information to allow care to be provided to the patient

____ Providing information to the physician regarding the care provided by Compassion HealthCare

____ Support the payment of an insurance claim

____ Other: _____

This authorization will be valid for the period of twelve months unless otherwise specified below:

I understand that I may revoke this consent at any time by sending a written notice to Compassion HealthCare understand that any release which has been made prior to my revocation which is made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality. I understand that I may review the disclosed information by contacting Dr. Zambelli and/or Compassion HealthCare

_____ _____

Signature of Patient or Authorized Representative Relationship of Authorized Representative

_____ _____

Date Representative Date