COMPASS
COUNSELING & PSYCHOLOGY SERVICES

Release of Information Authorization

Client Name: _____ Date of Birth: _____

The undersigned hereby authorizes the release of information from the medical and psychological record of the above named individual (check appropriate boxes below):

To and From:

Compass Counseling & Psychology Services
7984 New LaGrange Road
Louisville, KY 40222
Phone: 502-426-2777
Fax: 502-426-2776

To and From:

_____
_____
_____
_____
_____

Purpose of Release:

____ Coordinate Care ____Other (Explain):_____

Type of Information to be Release:

____ Dates of Treatment ____ (Neuro) Psychological Evaluation ____ Progress Notes
____ Scheduling and Billing ____ Gender/Sexual Identity-related information (Including Letters)
____ Other (Please Specify)_____

This authorization shall remain in effect for one year or 365 days.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that this office has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of treating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____

Signature of Patient or Representative Date

_____ _____

Representative's relationship the patient Compass Staff Witness

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www.compasscaps.com