

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient's PRINTED Name:	Birth date:	Social Security No
Address:	Home Phone Number: ()	Work Phone Number: ()

I hereby authorize Compass Counseling Center to disclose records obtained in the course of my evaluation and/or treatment to:
 (Name and address of person or organization to which disclosure is to be made)

Name:	Address:
Phone Number : ()	Fax Number: ()

Medical Records: (Entire Record or Selected Portions of PHI as marked below)

Description:	Date(s)	Description:	Date(s)	Description:	Date(s)
<input type="checkbox"/> Entire Records (or portions indicated): <input type="checkbox"/> Test results		<input type="checkbox"/> Consult Report(s) <input type="checkbox"/> Psychological Record <input type="checkbox"/> Progress Notes		<input type="checkbox"/> Billing Record <input type="checkbox"/> Verbal Report <input type="checkbox"/> Other_____	

_____ (Initials) I DO or I DO NOT consent to release of information relating to psychiatric or psychological testing or treatment, biofeedback training, alcohol and/or drug abuse diagnosis, prognosis and treatment, or such disclosure shall be limited to the following specific types of information: _____

List the purpose(s) for the release or disclosure of Protected Health Information: (optional) _____

This consent is subject to written revocation by the undersigned at any time except to the extent that action has been taken and if not earlier revoked. To revoke this authorization contact Compass Counseling Center for assistance.

This consent shall remain valid from the date of the signature until: Expiration date: _____ or Expiration Event: _____ None: _____, or define: _____

- I understand that :**
- Information disclosed by this authorization may be re-disclosed by the recipient of your PHI. Such re-disclosure will no longer be protected by this authorization.
 - I have the right to receive a copy of this authorization. Copy of the authorization received. _____ (Initials)
 - A copy or facsimile (fax) of this authorization is as valid as the original.

I hereby release Compass Counseling Center from any and all legal liability and injuries that arise from the release of this information to the party named above. The information that I am requesting may be sent by U.S. mail service and /or electronic facsimile and /or E-mail to the party named above.

I have read the above or have had it read to me and I authorize the disclosure of the Protected Health Information as stated.

SIGNED: _____ (Signature of Patient/Legal Guardian or Representative) If signed by other than patient, indicate relationship: _____	DATE: _____
Witness: _____	DATE: _____

To the Party Receiving this Information: This information has been disclosed to you from the records whose confidentiality may be protected by state and/or federal law. Certain regulations prohibit you from further disclosure of it without the specific written consent of the person to whom it pertains, or otherwise as permitted by such law and regulations.

Compass Counseling Center
 2685 S. Rainbow Blvd., Ste. 209
 Las Vegas, NV 89146

Phone: (702) 368-4585

Fax: (702) 368-2177