AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

You may give Compass Health Administrators written authorization to disclose your protected health information (PHI) to anyone that you designate and for any purpose. If you would like to authorize a person or entity to receive your PHI upon their request, please provide the information below. Completion of this form is not a condition or requirement of coverage and will not change the way Compass Health Administrators communicates with you. For example, we will continue to send explanation of benefits (EOB) to you, however if the person(s) authorized by you below call to inquire about you, your PHI will not be shared with them unless you have given permission to Compass Health Administrators by completion of this form.

Protected Health Information requested for:

Member Name: _____ Date of Birth: _____

Member ID Number: _____ Telephone: _____

Address: _____

I authorize Compass Health Administrators to disclose my Protected Health Information to the person(s) listed below:

Name: _____

Address: _____

Telephone: _____ Relation to Patient: _____

Name: _____

Address: _____

Telephone: _____ Relation to Patient: _____

I authorize Compass Health Administrators to disclose the following Protected Health Information:

☐ All of my health information in relation to my Medical benefits

☐ Only the following information:_____

I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. If I revoke my authorization, the information described above may no longer be used or disclosed for the purpose described in this authorization. **Unless revoked earlier, this authorization will expire on the earlier of one (1) year from the date of signing or on** _____.

Signature of Patient or Patient's Legal Representative: _____ Date Signed: _____

Print Name (If other than patient, proof of authority is required): _____ Relationship to Patient: _____