COMPASSION SERVICES

AUTHORIZATION TO OBTAIN, RELEASE, OR REVIEW PROTECTED HEALTH INFORMATION

I, _____ (Parent/Legal Guardian or Patient/Legal Representative), hereby authorize Compassion Services, LLC to:

☐ Allow Reviewed Records of Protected Health Information for:

☐ Release Copies _____ _____
Patient Name Date of Birth

☐ Obtain Records

From:
Name of individual, healthcare facility or agency:_____

Address of individual, healthcare facility or agency:_____

Phone:_____ Fax:_____

Send Records to: Compassion Services, LLC Fax: 606-437-3001
For the purpose of:

☐ Continued Treatment ☐ Personal Use ☐ Patient Communication
☐ Other (Please specify)_____

Date(s) of Service: From_____ To_____

This authorization will expire on the following date, event, or condition:_____
If I fail to specify an expiration event or condition, the authorization will expire in one year. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. Mental Health, alcohol, drug, IV and/or AIDS information is confidentially protected by Federal and state law which prohibits disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulations. I further request that no genetic counseling/testing information in my record be released without my written authorization, except as otherwise required by law. I understand that I may select the information from the list below to be released by placing my initials in the space provided. The potential for information disclosed pursuant to the authorization to be subject to redisclosure by the recipient and no longer protected by this rule. I further understand that Compassion Services,

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LLC may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization.

Place your initials by each item to be released or reviewed:

_____Complete Record
_____Abstract Record

_____ All Diagnostic Test Results
_____Therapy Records
_____ Consultation/Progress Notes
_____ Radiology only
_____ Pathology/Operative Report(s)
_____Lab only

_____Other (Please specify)
_____

In addition, place your initials by each specific item: (If applicable)

_____ Mental Health
_____ Drug and/or Alcohol
_____ HIV Testing
_____ Genetic Counseling/Testing Information
_____AIDS Information

Patient Name:_____

Patient Date of Birth: _____

_____ _____
Parent/Legal Guardian or Patient/Legal Representative Signature Date of Authorization

140 Adams Lane Suite 300 Pikeville, KY 41501
Phone: 606-230-2255
Fax: 606-437-3001