COMPASS
BEHAVIORAL HEALTH PLLC
Helping you find your way

11921 Freedom Drive, Suite 550
Reston, Va. 20190
T: 703-783-4375 F: 571-376-6564
admin@compassbehavioralhealthva.sprucecare.com

PERMISSION TO OBTAIN/RELEASE RECORDS

I, _____, _____, give my permission for
(patient/guardian name) (patient's DOB)
Compass Behavioral Health , PLLC to ☐ release ☐ obtain my medical records to/from

_____ so they can better understand my condition
(doctor/hospital/clinic/individual)

Tel:_____Fax.:_____

PERMISSION TO OBTAIN/RELEASE SENSITIVE INFORMATION:

By putting my initials by each item below, I understand that I give permission for records to be sent/obtained that may contain information about:

_____ my mental health,
_____ any transmittable diseases I may have (such as HIV/AIDS, Tuberculosis, or MRSA)
_____ genetic records,
_____ drug and alcohol records, and/or
_____ billing and insurance.

I UNDERSTAND THAT:

- I do not have to give my permission to share these records.
- If I want to revoke this permission, I need to talk to my doctor or a staff person and provide written documentation of my decision
- This form is only good for the time client is being treated with a Compass Behavioral Health clinician.
- I have the right to revoke this authorization, in writing, at any time by sending written notification to Compass Behavioral Heatlh at admin@compassbehavioralhealthva.sprucecare.com I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.
- Unless I have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information, as permitted by this authorization in any manner that we deem appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format, or electronically.
- There is a potential that the protected health information that is disclosed pursuant to this authorization may be disclosed again by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protection

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EXPIRATION:

Unless sooner revoked, this authorization expires in one year, or on the following date:_____

Patient Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____