Compass Health
835 Central Ave Suite 200 Dover, NH 03820 Phone: 603-749-0001

HIPAA Privacy and Release of Information Authorization

By signing this page, I authorize this practice and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve billing claims and health benefit coverage issues.

I understand that any personal health information or other information released to the person/organization identified on a release, may be subject to re-disclosure by the person it is being sent to; and therefore, is no longer protected by Compass Family Health.

I understand that I have the right to revoke this authorization by providing written notice, but understand this authorization may not be revoked if it's employees or agents have taken action on this authorization prior to receiving my written notice of intent to revoke this authorization. I also understand that I have a right to have a copy of this authorization. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my receipt of care or eligibility for benefits or enrollment of services, but may impact my responsibility to pay my provider directly and bill my insurance on my own behalf.

I have been advised of this practice's privacy practices, release of billing information policy, assignment of benefits policy, and grant the practice medication history authority, including access to my current medication record.

By signing below, I acknowledge that all my questions have been answered and I am signing this document willingly.

Patient Name _____ **DOB** _____

Patient Signature _____ **Date** _____

Or

*Legal Representatives: By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

Signature Representative _____ **Date** _____

Print Name of Representative _____ **Relationship**_____