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

DISCLOSURES OF PROTECTED HEALTH INFORMATION

I allow my treating health care providers and their staff to discuss my care with the offices and individuals named below., because these individuals play some role in my care, either by assisting me directly or by offering support to me and other family members.

This document is not a Health Care Power of Attorney. The sole purpose of this form is to protect my privacy by ensuring that my health care will be discussed **only with** individuals I have provided permission.

I understand that I may designate as many individuals as I want, and *that I am not required to designate any such individuals.* I also understand that my health care providers may discuss my care with individuals not listed below if I give my verbal consent for such discussions to occur, but that written consent is required for records to be released. I understand that I may retract permission to share my information with anyone on this list and I have the right to fill out a new form that will supersede previous ones.

Initial the below practices if applicable:

_____ Compass Hormone Health; Dover, NH

_____ Somersworth Physical Therapy; Somersworth, NH

_____ Lighthouse Physical Therapy; Dover/Portsmouth NH

_____ Londonderry Gastroenterology; Londonderry, NH

_____ Better Gut Better Health; Newington, NH

_____ Woman's Life Imaging, Somersworth, NH

_____ Core Endocrinology; Hampton, NH

_____ Atlantic Digestive Specialists, NH

I understand that this form does NOT give the individuals named below any authority to make health care decisions for me. It also does NOT allow them access to my medical records or documents.

1.____ ________________________________

Name of Individual Authorized to Receive Information   Relationship

2.____ ________________________________

Name of Individual Authorized to Receive Information   Relationship

3.____ ________________________________

Name of Individual Authorized to Receive Information   Relationship

OR

_______ I choose to authorize **NO ONE** at this time.

Patient Name ____ **DOB** ____________________

Signature Patient / Guardian ____________________________________ **Date** ____________________

Print Name of signer if not patient _______________________________ **Relationship**________________