Compass Family Health LLC
& Compass Hormone Health LLC; DBA Compass Customized Health & Wellness

Protected Health Information Authorization to Share Medical Records

Patient Name: _____ DOB:_____

Other Last Names: _____ Phone: _____

Address: _____

This signed release will authorize **Compass Family Health** at 835 Central Ave Suite 200 Dover, NH 03820 and **Compass Hormone Health** -also doing business as **Compass Customized Health & Wellness** at 835 Central Ave Suite 226 Dover, NH 03820, to continuously disclose and exchange my protected health information between the two entities as needed to provide me with comprehensive care.

***Information to be Disclosed:** *(Please **initial your preferred** the option(s) below).*

_____**Complete Medical Record** (This includes general health information and testing AS WELL AS applicable information related to mental health, drug or alcohol treatment, genetic testing, STD testing, HIV/AIDS, and psychotherapy notes.)

____ **Complete Record** as Above, Except I **DO NOT** authorize the disclosure of:

_____ Information related to mental health

_____Drug or alcohol treatment

_____Genetic testing

_____STD testing

_____HIV/AIDS testing or care

_____Psychotherapy Notes

I understand that the providers at Compass Family Health will continue to care for me and treat me, regardless of whether or not I sign this Authorization for Release of Records. I understand that this authorization may be subject to re-disclosure by the Receiving Health Care Agent for coordination of care.

I understand that I may revoke this Authorization at in time, by informing Compass Family Health in writing. Any revocation will not apply to disclosures that have already made. I understand that if this authorization is used to coordinate insurance coverage, I may not have the right to revoke it since insurance requires this information. I understand that I have a right to receive a copy of the information I am consenting to release.

This Authorization will expire twelve (36) months from the date this form is signed.

_____ _____

Printed Name Date

_____ _____

Signature of Patient or Legal Representative Relationship to Patient (if not patient)