COMPASS
FAMILY MEDICINE
Your Guide to Better Health

Release of Medical Information

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

I hereby authorize the release of the following protected health information:

□ Entire Medical Record

□ Office Notes/Visit Summaries □ Mental Health Records □ Pathology Reports

□ Radiology Reports □ Laboratory Reports Date(s):_____ □ Other: _____

Delivery Method: □ Paper Copy □ Electronic Copy

The purpose for this request to release medical information is: □ Medical Care/Treatment □ Insurance □ Personal Use

□ Other (specify): _____

Send my medical information to:

Name: _____

Address: _____

City: _____ State:_____ Zip: _____ Fax: _____

I understand that:

- By signing this form, I am authorizing the use or disclosure of protected health information as indicated above.
- I may revoke this authorization at any time before the information I have requested is released by providing written notice of revocation to compassfamily@myupdox.com.
- If the receiving party is not subject to medical records privacy laws, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law. Compass Family Medicine shall not be held liable for any consequences resulting from re-disclosure.
- A copy of this signed form will be provided to me upon request.
- Compass Family Medicine may charge an administrative fee to cover the cost of labor, copying, and postage. The physician's office will inform me of any charges and arrange for payment.
- This Authorization expires one year from date of signature (unless otherwise cancelled).

Patient/Representative Signature: _____ **Date:** _____

If the patient listed above is a minor or is unable to sign and you are a parent, legal guardian, or personal representative signing on behalf of this patient, please sign above and complete the following:

Print Name: _____

Relationship to patient: _____