COMPASS COUNSELING SERVICES

Orlando Office
1400 North Semoran Blvd Orlando, Suite E. FL 32807
Phone: (407) 823 - 8421 / Fax: (407) 823 - 8195

Kissimmee Office
201 Ruby Avenue, Suite B Kissimmee, FL 34741
Phone: (407) 933 - 1847 / Fax: (407) 933 - 1849

Records Release of Authorization for the Release of Protected Mental Health Information

This is a records release of authorization for Compass Counseling Services, LLC (CCS) to release, obtain, and/or exchange of protected mental health information. By signing this form, confidential psychological and psychiatric information can be released to and/or discussed with the people or agencies listed below unless noted by exclusions or limitations. This form is signed voluntarily and may be revoked at any time. All disclosures made pursuant to this form are valid as long as they were made before the date of revocation.

Client Name: _____ **Client Date of Birth:** _____/_____/_____

1. PLEASE CHECK:

☐ I hereby **REFUSE** to give CCS authorization for any release of information, including my primary care physician (PCP), at this time.

☐ I authorize my CCS provider/CCS to ☐ **RELEASE** ☐**AND RECEIVE** psychological/psychiatric mental health information to/from the SECOND PARTY as directed below:

2. SECOND PARTY:

Name: _____

Address: _____

Fax Number: _____ **Phone Number:** _____

3. TYPE OF INFORMATION TO BE DISCLOSED:

☐ I authorize disclosure of **ALL** health information, including information relating to medical, pharmacy, mental health, substance abuse, and psychotherapy.

☐ I authorize **ONLY** the disclosure of the following information: ☐ **Client Confirmation Letter** ☐ **Counseling Assessment with Treatment Plan**
☐ **Counseling Discharge Summary** ☐ **Psychiatric Evaluation/Assessment with Treatment Plan** ☐ **List of Psychiatric Medications**
☐ **Laboratory/Diagnostic Test Results** ☐ **Medication Progress Notes** ☐ **Psychological Evaluation/Testing Results from CCS**
☐ **Substance Abuse Treatment Record** ☐ **Other (specify):** _____

4. PURPOSE: ☐ **Insurance/Payment** ☐ **Personal Use** ☐ **Participation in Sessions** ☐ **Legal Action** ☐ **Client Communication/Coordination of Care**
☐ **Treatment Information** ☐ **Continued Treatment** ☐ **Appointment Coordination**
☐ **Other (specify):** _____

5. Note any exclusions or limitations here: _____

I certify that my health information is being disclosed at my request or at the request of my personal representative. I understand that treatment, payment, enrollment in a health plan, or eligibility for benefits is not dependent on my signing this authorization. By signing below, I acknowledge that I have read and understand this document and that I have voluntarily given CCS/my provider authorization to disclose my records. I understand that I may revoke this authorization at any time by providing a written notice to my provider. However, the revocation will not have an effect on any actions taken prior to the date my revocation is received. I understand that my information may be redisclosed by the authorized person/organization receiving the information, and at that point, the information may no longer be protected under the terms of this agreement. I am also aware that utilizing my health and or my mental health records for legal purposes are left up to the interpretation by legal representatives and may or may not be beneficial to my legal case. This authorization **will expire one year** following the date signed unless revoked in writing.

I understand that a request for documentation will take minimum of 7-10 business days to be completed. I understand that there may be a fee for the requested documentation, and I agree to pay all associated fees before receiving the requested documentation. (Please consult office staff to determine associated fees). I also understand that the request for documentation may contain personal and sensitive information, and I agree to the release of this information as requested.

_____	_____	_____
Print Client's Name	**Signature of Client**	**Today's Date**
_____	_____	_____
Print Name of Legal Guardian or Representative	**Signature of Legal Guardian or Representative**	**Today's Date**

Please check (if applicable): ☐ Authorization is given on this patient's behalf due to being a minor or unable to sign.