Patient Consent Release of PHI

Authorization for Use and Disclosure of PHI

Authorization for Use/Disclosure of Information: I hereby voluntarily consent to authorize my previous health care provider, to disclose my health information, for the purpose of providing home health care to the recipient that I have identified below.

CLIENT NAME: **DOB:** **LAST 4 OF SSN:**

FROM: Previous Health Care Provider: I authorize my health care records be released from:

Name:	
Address:	
City, State, Zip Code:	

TO: Recipient of Information

Name:	COMPASSIONATE HEALTHCARE SYTEMS LLC
Address:	1275 ELM STREET SUITE D
City, State, Zip Code:	WEST SPRINGFIELD MA, 01089

Information to be disclosed: I authorize the release of the following health information: (check the applicable box below)

- ☐ All my health information that the provider has in his or her possession, including information relating to any medical history, mental, or physical condition and any treatment received by me.
- ☐ Only the following records or types of health information: provide specific authorization the disclosure of the following types of confidential information (Client initials where appropriate):
  _____HIV records _____ Alcohol/substance abuse diagnosis/treatment records
  _____ Psychiatric/Psychotherapy records _____ Other: Specify:

TERM: I understand that this authorization will remain in effect while I am a client at Compassionate Healthcare Systems LLC.

RIGHT OF CLIENT TO RECEIVE A COPY OF AUTHORIZATION

I understand that I have the right to receive a copy of this signed authorization if I want to.
I have received a copy of this authorization. ☐ Yes ☐ No

THIS RELEASE SHALL EXPIRE ONLY UPON MY WRITTEN AUTHORIZATION

Print Patient or Representative Name:	
Patient or Representative Signature:	**Date:**
Clinician Signature/Title:	**Date:**