



Compass North

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AUTHORIZATION FOR THE EXCHANGE OF INFORMATION

Clients Name: _____ Date of Birth: _____

I give Compass North permission to: Give information to
 Receive information from

Outside Agency and/or Individual's Name

Address, City, State, Zip Code

Phone Number

Fax Number

Approximate Dates of Requested Information: _____
Information is being used for the purpose of: _____

Types of information to be disclosed by mail, telephone, email, or facsimile are as follows:

- | | |
|---|---|
| <input type="checkbox"/> Diagnostic Assessment | <input type="checkbox"/> Billing & Financial information |
| <input type="checkbox"/> Treatment Plan | <input type="checkbox"/> Psychological Testing |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Progress in Treatment |
| <input type="checkbox"/> Rule 25 CD Assessment | <input type="checkbox"/> Alcohol/Drug Abuse History/Treatment |
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Verbal Consultation as Necessary |
| <input type="checkbox"/> Other (Specify): _____ | |

Records related to chemical dependency, mental health, or HIV/AIDS will be released, unless otherwise indicated by initialing here: _____

I understand that I have a right to revoke my authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Compass North. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by protected by federal laws and regulations.

I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure mental health treatment.

This authorization expires on _____
If I fail to specify an expiration date or event, this authorization expires one year from the date on which it was signed.

Client Signature

Compass North Staff

Parent/Guardian Signature

Date