COMPSYCH®
— The GuidanceResources Company® —

Authorization Form

I, the undersigned **("Client")**, hereby authorize ComPsych® Corporation's Privacy Official to release/disclose to:

____

(Name of Individual or Entity)

____

(Address of Individual or Entity)

The following information contained in Client's clinical record maintained by ComPsych:

- ☐ Entire copy of clinical record maintained by ComPsych;
- ☐ Information necessary to handle a billing and/or claim question;
- ☐ Information necessary to facilitate treatment; or
- ☐ Other

If Other, please describe the specific records and/or other information to be disclosed:

____

____

____

My authorization for the release/disclosure of the above information is effective on the date I sign this form and will remain effective for a period of one (1) year from such date.
The purpose of the disclosure by ComPsych to the recipient is:

____

____

I understand that ComPsych will not condition treatment or payment or the eligibility of my receiving services on the basis of my providing authorization for the requested use or disclosure, and that I may refuse to sign this authorization. To the extent that I do sign this authorization, I do so voluntarily. I understand that I have the right to inspect and copy the information that I have authorized to be used or disclosed as provided for under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") regulations found at 45 C.F.R.§ 164.524.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.

I understand that this authorization is valid until it expires, unless revoked by me before then. I understand that I may revoke this authorization at any time by sending written notice of my desire to do so to ComPsych. I understand that if I revoke this authorization such revocation will not be effective to the extent ComPsych has already relied on it to disclose the information.

Signed: ______________________________ Date: ________________
If you are not the client, please specify your relationship to the client: ____________.
Witness: ______________________________ Date: ________________

Client Name: **Date of Birth**:

Client Address:

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ComPsych - NBC Tower - 455 North Cityfront Plaza Drive
Chicago, IL - 60611-5322

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Authorization Form Instructions

The following are instructions on how to properly complete and submit an Authorization Form for the release and/or disclosure of protected health information (PHI):

1. Complete ***all areas*** of the Authorization Form
    a. In the first section list the name and address of the person who will receive the information
    b. Check off the information requested
    c. Sign and date the form
    d. Print the name of the client, the client's date of birth, and the client's address in the bottom section of form

2. Submit Authorization Form via standard mail to:

    Attn: Privacy Official
    ComPsych Corporation
    NBC Tower
    455 North Cityfront Plaza Drive
    12th Floor
    Chicago, IL 60611

    Or fax to:

    Attn: Privacy Official
    312.705.1521

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