



AUTHORIZATION TO REQUEST AND/OR RELEASE INFORMATION

REQUEST INFORMATION

RELEASE INFORMATION

For an Adult: I, _____, Client Name please print

For a Minor: I, _____, Parent/Legal Guardian Name please print, the parent/guardian of _____, Name of Minor (less than 18 years of age) please print, a minor,

hereby authorize and direct Compass Professional Services LLC to obtain from

_____ the following information:
Person or Organization

- Admission report / notes
- History of presenting problem
- Medical history
- Psychological reports
- Psychiatric reports
- Psychosocial reports

- Educational records and reports
- Progress notes
- Treatment plan with progress reports
- Discharge summary with diagnosis
- Prognosis and aftercare plan
- Other _____

to be used for the purpose of outpatient services at Compass Professional Services LLC.

Furthermore, I hereby authorize Compass Professional Services LLC to disclose to

_____ the following information:
Person or Organization

This information has been obtained from and/or disclosed to Compass Professional Services LLC or the above person, organization, or agency from records whose confidentiality is protected by Montana and/or Federal Law. These regulations prohibit Compass Professional Services LLC or the above person, organization, or agency from making any further disclosure of this information without prior written consent.

I understand that I have no obligation whatsoever to disclose any information from my record, and I understand that I may revoke this consent at any time by notifying Compass Professional Services LLC or the above person, organization, or agency in writing and/or by specifying an event or condition upon which my consent will expire without revocation. I have read or had this form read and explained to me and I understand its contents.

I have completed the above to the best of my ability and fully understand the importance of this relationship. I give my consent and with my signature give permission to request and/or release this information. This authorization will automatically expire in 12 months from the date signed.

Client Signature

Date / ____ / ____

Client Signature

Date / ____ / ____

Parent/Legal Guardian Signature mandatory if client is a minor

Date / ____ / ____

Parent/Legal Guardian Signature mandatory if client is a minor

Date / ____ / ____

Therapist/Representative of Compass Professional Services LLC

Date / ____ / ____