AUTHORIZATION TO USE & DISCLOSE PRIVATE HEALTH INFORMATION

COMPASS
Healthcare Redefined.
Phone: 800.513.1667 ***/ Fax:*** 844.335.7117

I hereby authorize all licensed health care practitioners, my health plan, and other persons who have participated in providing or paying for any health care service to me to disclose my individually identifiable health information as described below to **Compass Professional Health Services (also doing business as Life Account LLC) and/or specific health care providers as instructed by Compass PHS**. I authorize for **Compass PHS** to act on my behalf in gathering the information necessary to analyze and resolve billing or benefit questions.

I understand that:

a) Compass PHS will acquire and maintain my personal health information solely for the purpose of my continuing medical care and analysis and resolution of billing and benefit issues. My signature to execute this Authorization is voluntary.
b) Treatment, payment, or eligibility cannot be conditioned on my signing this Authorization.
c) Information disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected.
d) This Authorization will remain in effect until twelve months after the signature date below.
e) I can revoke this authorization at any time by sending written notice to Compass PHS, 901 Main Street, Suite 5800, Dallas, TX 75202. The revocation will not affect any actions taken before the receipt of the written revocation.

First: _____ Last: _____ MI: _____ **Legal Name**

_____ / _____ / _____ **Date of Birth**

M ☐ F ☐ **Sex**

_____ **Address** **City** **State** **Zip**

_____ **Email Address**

_____ **Phone**

First: _____ Last: _____ MI: _____ **Compass Member Name** *(if different)*

City of New Braunfels **Employer**

	Insurance Company *(ex. Aetna)*	***Customer Service Phone Number*** *(back of your insurance card)*	***Group #***	***Member ID #***
Medical	United Healthcare	844-554-5512	914942	
Dental	CIGNA	800-244-6224	55982	
Vision	Superior Vision	800-507-3880	036492	

I understand that Compass PHS:

- Provides services directly to me. My employer is in no way responsible for the actions and/or results of service from Compass PHS. **As such, Compass PHS is committed to protecting my privacy and will not share my personal information with my employer or an unauthorized third party without my express consent.**
- Is not a provider of medical or health care and does not practice medicine or give medical advice. My providers, who are not employees of Compass PHS, and I are responsible for verifying the accuracy of all information gathered, generated, and provided by Compass PHS with regards to my health.
- Compass PHS should not be used in situations requiring urgent or emergent care.

_____ **Signature OR Printed Name of Legal Representative**

_____ / _____ / _____ **Date**

☐☐☐☐ **Last 4 of Social**

_____ *Signature of Legal Representative (if not signed by patient)*

_____ *Relationship to Patient (if not signed by patient)*

A photocopy of this document is as sufficient as the original.