Compass Research, LLC.

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Authorization for Release of Confidential Information

I, ____, hereby authorize to release all Protected Health Information (PHI) including medical, psychiatric, drug or alcohol abuse, HIV testing, ARC or AIDS information or any other records of a sensitive nature from ____ to:
(Name of Hospital, Individual, or Agency)

Compass Research, LLC.
100 West Gore Street Suite 202
Orlando, Florida 32806
Phone: (407) 426-9299
Fax: (407) 426-9290

My records are to be released for the purpose of:
____
____

Research Study ____

_X_ All Appropriate Records

I understand the consent is revocable upon written notice to the hospital, except to the extent that action by the hospital has been taken in reliance on this authorization shall remain in force for one year or during pendency of this claim in order to affect the purpose for which it is given. Any such disclosure shall be limited to information that is reasonably necessary for the discharge of the legal or contractual obligations of the insurance company.

To the Party Receiving this Information:
Alcohol and drug abuse information, of present, has been disclosed from records who confidentiality is protected by Federal Law Federal regulations (42 CFR, Part 2) which prohibit making any further disclosure of it without the specific written authorization of the undersigned, or as otherwise permitted by such regulation. A general authorization is not sufficient for this purpose.

******Appropriate state statues protect HIV/AIDS information******

_____________ (Date of Authorization)

_________________________ (Patient's Signature)

_________________________ (Witness)

_____________ (Date of Birth)

_________________________ (Parent/Legal Guardian, Authorized Representative's Signature, Power of Attorney, Spouse, Other)