AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, hereby authorize the use of or disclosure of my health information as described in this authorization.

1. **Right to revoke.** I understand that I have the right to revoke this authorization at any time by notifying Compass Group USA, Inc. in writing at the following address:

   Compass Group USA, Inc.
   c/o Mr. Robert Kovacs
   2400 Yorkmont Road
   Charlotte, NC 28217

   I understand that the revocation is only effective after it is received and logged by Compass Group USA, Inc. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

2. **Re-disclosure.** I understand that information authorized to be used or disclosed under this authorization may be subject to re-disclosure by the person or organization receiving it and no longer protected by federal law.

3. **Conditioning on an Authorization.** My treatment, payment, or enrollment in a Compass Group USA, Inc. health plan or eligibility for benefits may not be conditioned on my agreement to sign this authorization.

4. **Copy of Authorization.** I understand that I am entitled to receive a copy of this authorization.

Employee Information:
Name: _____
Address: _____
Telephone Number: _____
Social Security Number: _____

Person/Organization Requesting to Use or Disclose the Information:
Name: _____
Address: _____
Telephone Number: _____

Person/Organization Who Will Receive this Information:
Name: _____
Address: _____
Telephone Number: _____

Description of Information to be Used or Disclosed:

_____
_____
_____

Description of Each Purpose of the Disclosure:
(If you do not wish to state a purpose, please state, "At the request of the individual.")

_____
_____
_____

Expiration Date or Event for the Authorization:

_____

Signature of Employee or Personal Representative: **Date:**

_____ _____

Personal Representatives Section:
Name of Personal Representative:_____
Address of Personal Representative: _____
Telephone Number of Personal Representative:_____

If a Personal Representative executes this form, that Representative warrants that he or she has authority to sign this form on the basis of:

_____
_____