clarity
The speech, hearing, and learning center.

Discovering Potential
Empowering Communication
Transforming Lives

Authorization to Obtain and Release Information Form

☐ Release
☐ Obtain

PATIENT INFORMATION FOR:

Patient's last name	Patient's first name	Patient's middle name

Patient's date of birth	Patient's Social Security number

To/From:_____

_____

for the purpose of providing information to assist with the care and treatment of the above named patient.

☐ **I authorize for my complete health record or school record to be released/obtained with the exception of the following information:**

☐ Please Specify : _____

_____

I understand that the records and/or related information to be obtained may contain information of a personal and confidential nature. I understand that my records are protected generally under state and federal laws as well as statutes governing specific types of information and cannot be disclosed without my written consent, except for treatment, payment or administrative purposes as outlined in Clarity, The Speech, Hearing & Learning Center's Notice of Privacy Practices. This authorization is subject to revocation at any time, provided action has not been taken, by so notifying Clarity, The Speech, Hearing & Learning Center in writing. This authorization shall be in force and effect until five years from the date signed or until the patient reaches the age of majority (18 years of age), whichever comes first, at which time this authorization expires. I understand that I have a right to receive a copy of this Authorization form. Please **send this form to:**

Privacy Officer
Clarity, Inc.
The Speech, Hearing & Learning Center
29 N. Academy St.
Greenville, SC 29601

Date	Signature of patient or personal representative	Relationship to patient (if other than patient)