70 years of clarity
the speech, hearing, and learning center

Discovering Potential
Empowering Communication
Transforming Lives

AUTHORIZATION TO OBTAIN INFORMATION

This form permits CLARITY, Inc to obtain protected health information from individuals or agencies that may not be a part of regular treatment, payment or administrative activities related to patient/client care. This authorization shall be in force and effect until six years from the date signed or until the patient/client reaches the age of majority (18 years of age), whichever comes first, at which time this authorization expires.

PATIENT INFORMATION:

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

Patient's date of birth _____

INFORMATION REQUESTED FROM:

Name: _____ Phone: _____
Fax: _____

Address: _____

City/State/Zip: _____

INFORMATION TO BE RELEASED TO CLARITY, INC:

☐ Medical Records (Please check all that apply):
☐ Health ☐ Hearing ☐ Speech ☐ Psychological/Mental Health ☐ Other _____

☐ School Records (Specify)_____

☐ Other _____

PURPOSE OF THE REQUEST: □ Continuum of Care □ Other: _____

RIGHTS OF PATIENT/CLIENT

- I understand that I have the right to refuse to sign this Authorization and that my treatment will not be conditioned on signing.
- I understand that I have the right to revoke this authorization at any time by sending a written notification to the address listed at the top of this form I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.
- I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I hereby authorize the release of the requested information pertaining to services that were provided for the above named patient.

Date _____ Signature of Patient or Personal Representative (as defined by HIPAA) _____ Relationship to patient (if other than patient) _____

Description of Personal Representative's Authority (Attach necessary documentation):

_____

For Office Use Only:

Receiving Employee_____ Date Received_____

[ ] Scanned and Copy given to patient

Revised 12/5/2018