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

Discovering Potential
Empowering Communication
Transforming Lives

AUTHORIZATION TO RELEASE INFORMATION

This form permits CLARITY, Inc to use or disclose protected health information to 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 FOR:

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

____
Patient's date of birth

INFORMATION MAY BE RELEASED TO:

Name: ______________________________ Phone: __________ Fax:__________

Address: ____

City/State/Zip: ____

Email: ____

Email communications ***FROM*** *Clarity will be sent as encrypted messages. Emails sent* ***TO*** *Clarity by you (the patient/client or personal representative of the client) or the individual listed above may be unencrypted as this is not a standard feature of most email providers. Please be aware that email communications can be intercepted during transmission or misdirected. Your use or authorization for the use of email to communicate Protected Health Information or other information of a confidential nature to us indicates that you acknowledge and accept the possible risks associated with such communication.*

______Initial to acknowledge risks associated with email communication and to authorize Clarity to use email to communicate with the entity listed above.

Information to be released: ___________________________________

Purpose of disclosure: □ At the request of the individual □ Other: ____________________

□ To obtain information (Please Specify) ______________________

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.

__________	______________________________	____________________
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 8/15/2019