clarity

# Privacy Practices and Authorization for Disclosure of Medical Information

*The privacy of your medical information is important. We will only share information about the services you receive at Clarity, Inc. with person(s) you designate and via the mean(s) you specify. This authorization shall be in enforce for six years, until the patient reaches the age of majority (18 years of age) or until this authorization is revoked by the patient or the patient's personal representative.*

Patient Name: _____ (Last) _____ (First) _____ (Middle) Date of Birth: _____ (Month/Day/Year)

## PATIENT'S VERIFICATION CODE

Clarity, Inc. will verify the identity of a person requesting protected health information. Please provide a word/phrase that Clarity, Inc. can ask for to verify identity: _____

## SHARING INFORMATION WITH OTHERS

**Please CHECK the information below that you authorize Clarity, Inc. to give out for the above patient, and list who has permission to receive this information other than the patient's parents/legal guardians.**

☐ Results of Evaluations ☐ Appointment Information ☐ Billing Information ☐ Treatment Information

_____ Name of person that has permission to receive the above patient information _____ Relationship to Patient

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## COMMUNICATION BY PHONE

I authorize Clarity, Inc. to leave a voice message on the phone number below regarding: Check ONLY ONE

☐ All Information including appointments, general information, updates, billing etc.

☐ Appointment information ONLY

( ) _____ Phone Number _____ Relationship to Patient

## COMMUNICATION BY EMAIL

Please be aware that email communications can be intercepted during transmission or misdirected. Your use of and authorization for the use of email to communicate Protected Health Information or other information of a confidential nature with Clarity, Inc. indicates that you acknowledge and accept the possible risks associated with such communication. **Please CHECK the information below that you authorize Clarity, Inc. to release about above patient via email and the email address(es) you authorize Clarity, Inc. to send Protected Health Information.**

☐ Results of Evaluations ☐ Appointment Information ☐ Billing Information ☐ Treatment Information

_____ Email Address _____ Name of the account owner for this email address _____ Relationship to Patient

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## RIGHTS OF THE PATIENT

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 below. 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. Information received by this office is for our own use and will continue to be protected by our Privacy Policy. I understand that I have the right to inspect or obtain a copy of the protected health information disclosed as described in this document. I can do this by written notification to the address below.

**I authorize disclosure of the information listed above by the means specified and I have read and received a copy of the Notice of Privacy Practices for Clarity, Inc.**

_____ Signature _____ Relation to Patient _____ Date