clarity

RELEASE OF INFORMATION AUTHORIZATION

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

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

RELEASE RECORDS TO (Where do you want the information sent? Who may have the information?)

Name of individual, healthcare provider/hospital/practice: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Daytime Phone Number: _____ Fax Number: _____

OBTAIN RECORDS FROM (Who has the information you want released to Clarity, Inc?)

Name of individual, healthcare provider/hospital/practice: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Daytime Phone Number: _____ Fax Number: _____

RELEASE INSTRUCTIONS (How do you want the information released? Format Requested: (check one))

☐ Mail ☐ Fax (To healthcare provider ONLY) ☐ Phone call ☐ Other _____

PURPOSE OF RELEASE (Why is it needed?)

☐ Continuing Care ☐ Patient Request ☐ Insurance ☐ Disability ☐ School ☐ Other _____

I understand that fees for copies of medical records/images and postage fees may be charged as provided by SC Law

EVALUATION AND/OR TREATMENT DATE(S) (When were you seen?)

☐ Dates from _____to _____ (please be specific) **OR** ☐ All Treatment Dates

INFORMATION TO BE RELEASED (What do you want sent or released? Check the appropriate box)

Evaluation Reports: ☐ Audiological ☐ Hearing Aid ☐ Central Auditory Processing ☐ Speech/Language
☐ Feeding ☐ AAC ☐ Psychological/Psychoeducational ☐ Counseling

Treatment Information: ☐ Progress / Visit Note(s) ☐ Treatment Plan(s) ☐ Discharge Summary(ies)

Other ☐ _____

RIGHTS OF 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 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 understand I have a right to a copy of this authorization. Proof of identity may be required, attaching a copy of your photo ID is recommended. (NOTE: Allow 30 days for processing according to Federal regulation.)

_____ _____

Name of Patient or Legal Guardian/Representative Date

_____ _____

Signature of Patient or Legal Guardian Representative Relationship to Patient, if Signed by Legal Guardian

Document(s) of patient representative's authority must be attached if patient is not signing.

When requesting Clarity, Inc to send records, return this form to:

Clarity, Inc. | 29 North Academy Street | Greenville, SC 29601 | PH: 864-331-1400 | FAX: 864-331-1416