AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION/RECORDS

Clarity Health Solutions

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2055 Military Trail, Suite 306 * Jupiter, FL, 33458

I,_____ **DOB:**_____

hereby give my permission to **Clarity Health Solutions** to release or request from a third party information contained in my medical record. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, sexual abuse treatment, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions, and that under Florida law these records are classified as privileged and confidential and cannot be released to me or those designated by me or my legal guardian without an expressed and informed consent. In addition, I understand that those records will not be released to entities other than those designated by myself or my personal representative or otherwise provided in Florida or federal law.

This information will be released/requested upon request to the following:

To/From: _____

First and last name, phone, and address of person(s)

The type of information to be disclosed/requested is as follows:

To Be Released * *from* Clarity Health Solutions	**To Be Requested** * *from third parties*
____Treatment Plans	____Treatment Plans
____Process Notes	____Process Notes
____Health/Medical Records (if applicable)	____Health/Medical/Academic Records
____Letter(s) of Progress	____Psychological/Psychiatric Evaluations/Assessments
____Bio Psychosocial Evaluation/Assessment (if applicable)	____Court Documents
__ Verbal Communication	__ Verbal Communication
____Other (Specify): _____	____Other (Specify): _____

** In the case of notes documenting or analyzing the contents of conversation during a private counseling session ("process notes"), we reserve the right to provide a report of examination or treatment in lieu of copies of the actual records, unless requested by/for a treating psychotherapist (Florida Statute 456.057 and HIPAA Privacy Rule).*

____(initial) I understand that I have the right to withdraw my authorization at any time except to the extent that action has already been taken pursuant to the authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to **Clarity Health Solutions.**

____(initial) I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and **Clarity Health Solutions** will not base my treatment or payment whether or not I provide authorization for the requested use or disclosure. I understand that I may inspect or copy the information to be disclosed, as provided in CFR164.524 (with reasonable charge).

____(initial) I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and is no longer protected by federal confidentiality laws or **Clarity Health Solutions. Clarity Health Solutions** will not be held liable for information disclosed to another party per the client's request.

____(initial) I understand that **Clarity Health Solutions** will release only the minimum amount of information necessary to fulfill a request.

This authorization shall expire when the client is discharged from the current episode of care (treatment has been completed, the client rejects/declines/drops out of treatment, is referred elsewhere, moves, or in the case of the client's death.) This agreement is subject to revocation in writing at any time.

Release:

_____

Signature Client/Next of Kin/Guardian **Date**

_____

Clinician Signature/Credentials **Date**

Request:

_____

Signature Client/Next of Kin/Guardian **Date**

_____

Clinician Signature/Credentials **Date**