CLARITY HEALTH CARE
AUTHORIZATION FOR DISCLOSURE

Location (Check one):

☐ **Hannibal**
141 Communication Drive,
Hannibal, MO 63401
(P) 573-603-1460 (F) 573-603-1462

☐ **Quincy**
639 York Street,
Quincy, IL 62301
(P) 217-222-6277 (F) 217-214-5450

Full Name:_____

Social Security #:_____ Date of Birth: _____

Hereby authorize CLARITY HEALTH CARE and program/person identified below to communicate and disclose to one another written and verbal information regarding my treatment as indicated below:

Physician / Facility Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

Fax _____

I would like the following identifying information released from my records: **(Check Items That May Be Disclosed)**

☐ All medical records related to Physical/Mental healthcare information, (STD results require permission below) (Unless otherwise noted here):

☐ Immunization records

☐ Mental health evaluation results, Psychological Evaluation, legal information, intake assessment, psychological/psychiatric information, progress toward goals and discharge summary
Dates: _____ To _____

☐ STD results, HIV/AIDS testing whether negative or positive, to the person (s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.
{ Definition: Sexually Transmitted Disease (DTS) as defined by law, RCW 70.24 et seq, includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma vernereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome) and gonorrhea.}

☐ Release of any records regarding drug and/or alcohol treatment to the person(s) listed above.

{ I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Client Records, 42 CFR Part 2, and the Health Insurance Portability & Accountability Act of 1996 (HIPAA) and cannot be disclosed without written consent unless otherwise provided for in the regulations.}

The purpose of need for such disclosure is for: For Continuity of Care

I also understand that I may revoke this consent at any time, except to the extent that disclosures have already been made in reliance on this or any other consent. Revocation may be accomplished per written request and may be for specific items or the entire release.

This consent will automatically expire 1 year from date of signature unless there is a different specification of date, event, or condition noted.

I understand that Clarity Health Care may not generally condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

Would you like a copy of this authorization? Please initial: ( ) YES ( ) NO

Signature of Patient:_____ Date:_____

Signature of Parent/Guardian/Legal Rep:_____ Date:_____

(Specify relationship to client:_____)

(Witness Signature: _____) Date:_____