MONROE CITY SCHOOL DISTRICT

and

Clarity Healthcare/Preferred Family

Healthcare, Inc.

**Authorization for Disclosure**

| | |
|---|---|
| Patient Name: | |
| SS#: | DOB: |

I hereby authorize Clarity Healthcare and program/person identified below to communicate and disclose to one another written and verbal information regarding my treatment as indicated below:

| |
|---|
| Provider/Facility Name: |
| Address: |
| City/State/Zip: |
| Phone: |
| Fax: |

I would like the following identifying information released from my records:

| | |
|---|---|
| | All medical records related to physical/mental health, unless otherwise noted here (STD results require permission below): |
| | Immunization records |
| | Mental health evaluation results, psychological evaluation, legal information, intake assessment, psychological/psychiatric information, progress towards goals and discharge summary<br>Dates: _____to_____ |
| | STD results, HIV/AIDS testing whether positive or negative, 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<br>*Sexually transmitted disease (STD) is 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 |
| | Other (please list)<br>*Educational testing, IEP, scales, communication w/teacher and/or counselors |

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 and need for such disclosure is for continuity of care.
I 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 the date of signature unless there is a different specification of date, event, or condition noted.

I understand that Clarity Healthcare 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.

| Patient Signature | Date |
|---|---|
| Parent/Guardian Signature | Date |

If you would like a copy of this authorization, please initial: _____Yes _____No Witness Initials: ____

| Witness Signature | Date |
|---|---|