AUTHORIZATION FOR RELEASE OF INFORMATION

Clarity ADHD, PLLC | Lucas Craft, PA-C | Washington State

Purpose

This form gives Clarity ADHD, PLLC permission to release or obtain your health records as described below. This follows HIPAA and Washington State law.

Signing this form is your choice. Your care, payment, and benefits will not be affected if you do not sign.

Patient Information

Patient Name (print):

Date of Birth: **Phone:**

Email:

Direction of Release

I authorize Clarity ADHD, PLLC to **RELEASE** my protected health information as specified below **TO**:

Recipient

Name:

Organization:

Address:

Phone:

Fax/Email:

Records to Be Released

Check all that apply:

[ ] Psychiatric evaluation and diagnostic assessments

[ ] Medication list and prescription history

[ ] Treatment and progress notes

[ ] ADHD testing results (e.g., QBTest)

[ ] Billing and payment records

[ ] Other (describe): _____

Date Range of Records

To limit records to a specific time period, enter the dates below. Leave blank to release all records.

From: _____ **To:** _____

Special records - including therapy notes, substance use records, HIV/AIDS status, and genetic information - will only be released if you specifically authorize them below. I authorize release of the following special records, if applicable: _____

Purpose of Release

Check one or more, or describe:

[ ] Continuity of care / coordination with another provider

[ ] Personal request / records for my own use

[ ] Legal or administrative proceeding

[ ] Other: _____

Expiration

This authorization expires on the date you write below. If no date is written, it expires one year from the date you sign.

This authorization expires on:

[ ] When the purpose described above is complete (no fixed end date)

Your Rights

- You may cancel this authorization at any time. Send a written request to Clarity ADHD, PLLC. Cancellation does not apply to information that has already been shared.
- Once your information is shared, the recipient may re-share it. HIPAA may no longer protect it after that point.
- You may request a copy of this signed form at any time.
- You will not lose care, payment, or benefits if you do not sign this form.

Authorization

By signing below, I give permission for my health information to be used or shared as described in this form.

I know I may cancel this permission at any time, unless action has already been taken based on it.

Patient (or Personal Representative) Signature:

Date:

If signed by Personal Representative, describe authority/relationship:

Note: If a Personal Representative is signing on behalf of a patient, please provide a copy of the Power of Attorney, Guardianship Order, or other document that shows your authority. A copy will be kept in the patient record.