CLARITY THERAPY
NYC

Permission for Release of Information

I, ___________________________, authorize Clarity Therapy NYC to release or request from a third party information contained in my medical record.

Name of Individual or Office: ____

Individual or Office's Phone: ____

Individual or Office's Address:
____

____

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

To Be Released	To Be Requested
____ Treatment Plans and Diagnoses	____ Treatment Plans and Diagnoses
____ Process Notes	____ Process Notes
____ Health/Medical Records	____ Health/Medical/Academic Records
____ Letter(s) of Progress	____ Psychological/Psychiatric Evaluations or Assessments
___ Bio Psychosocial Evaluation or Assessment	____ Court Documents
___ Verbal Communication	___ Verbal Communication
____ Other (Specify):	____ Other (Specify):

I understand that I am giving my permission to Clarity Therapy NYC for disclosure of confidential health care records. I understand that my health care records 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 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.

I also understand that I have the right to revoke this consent, but that my revocation is not effective until delivered in writing to my health care provider.

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 federal law.

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 Therapy NYC. Clarity Therapy NYC will not be held liable for information disclosed to another party per this request.

I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and Clarity Therapy NYC will not base my treatment or payment on 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.

I acknowledge that a copy of this consent and a notation concerning the persons, offices, or agencies to which disclosure was made shall be included with my health care records. I understand this authorization shall expire when I am discharged from the current episode of care.

______________________________	______________________________	____________
Client/Authorized (PRINT)	Client/Authorized (SIGNATURE)	Date