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**HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION**

This form is for use when such authorization is required and complies with the Health Insurance

Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I. My Authorization

I authorize the following using or disclosing party:

Amy S. Clark, PsyD

to use or disclose the following health information.

\_\_\_\_\_ *Monthly billing statements by email*

The purpose of this authorization is (check all that apply):

☐ - At my request

☐ - Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorization ends:

☐ - On (date)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ - When the following event occurs: treatment has terminated and my balance has been paid in full

II. Communication Limits

All forms of communication are not 100% confidential and secure. By signing this form you are acknowledging your understanding of the confidentiality limits of email.

III. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except

where uses or disclosures have already been made based upon my original permission. I may

not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke

this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot

be taken back.

I understand that it is possible that information used or disclosed with my permission may be

redisclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this

authorization (unless treatment is sought only to create health information for a third party or to

take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as

valid as the original.

Signature of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the patient is a minor or unable to sign, please complete the following:

☐ - Patient is a minor: \_\_\_\_\_\_\_\_\_\_\_\_\_ years of age

☐ - Patient is unable to sign because: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Authorized Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Authorized Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authority of representative to sign on behalf of the patient:

☐ - Parent ☐ - Legal Guardian ☐ - Court Order ☐ - Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_