Amy S. Clark, Psy.D.

Clinical Psychologist

4423 S. 3rd Ave. Everett, WA 98203 Phone: (206) 719-5902
P.O. Box 12808 Everett, WA 98206 Email: dramyclark@icloud.com

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: _____