Clarke
Hearing Center

45 Round Hill Road
Northampton, MA 01060

V 413.582.1114
FAX 413.587.0383

clarkehearingcenter.org

Use and Disclosure of Health Information
to a Specific Person/Entity

Patient Name: _____ Date of Birth: _____
Address: _____ City/State/Zip: _____

I understand that HIPAA allows Clarke to use and disclose my protected health information without my authorization with certain exceptions. Additionally, I request and authorize Clarke School for the Deaf, Inc. and Clarke Pennsylvania, Inc., hereon referred to as "Clarke," to disclose my protected health information as described below. I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.

I consent to Clarke releasing protected health as detailed below.

My protected health information may be used or disclosed to the following:

_____
_____
_____

For the Purpose of:

_____
_____

I understand that this authorization is in effect until the revocation section of this form is signed or until written notice of revocation is received. I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to **Clarke.**

I authorize Clarke's use and disclosure of my protected health information as set forth above. I understand that this authorization is voluntary and that Clarke cannot condition my treatment, services, etc. on the signing of this authorization. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

_____ _____
Printed name of patient or personal representative Date

_____ _____
Signature of patient or personal representative Date

Expiration: This authorization will expire on (must choose one):

- ☐ One year from the date it is signed
- ☐ Other (insert date or event): _____

See reverse for revocation statement

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REVOCATION

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice to the address listed at the bottom of this form. I understand that revocation of this authorization will not affect any action the above named entity took in reliance on this authorization before the above named entity received my written notice of revocation.

I hereby revoke this authorization.

_____ _____
Printed name of patient or personal representative Date

_____ _____
Signature of patient or personal representative Date

Send written revocation to:
Clarke School for the Deaf
d/b/a Clarke Hearing Center
45 Round Hill Road
Northampton, MA 01060