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
Opt out option

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

I understand that I have the right to request restrictions as to how my protected health information may be used or disclosed by Clarke School for the Deaf, Inc. and Clarke Pennsylvania, Inc., from herein referred to as "Clarke."

☐ I have elected to pay for the services that were rendered to me today without accessing my health insurance. As a result, I elect to prohibit Clarke from using and disclosing medical information to any person or entity, including my health insurance and primary care doctor, other than required by HIPAA regulations and outlined in the Notice of Privacy Practices of Clarke.

☐ I wish not to receive communications regarding *any* treatment or health related products or services if that treatment or said services results in financial remuneration in exchange for making the communication.

☐ Instead of opting out of all communications, I wish to be contacted each time prior to receiving communications regarding treatment or health related products or services if that treatment or said services results in financial remuneration in exchange for making the communication.

☐ I wish to opt out of receiving fundraising communications from Clarke.

☐ I wish to restrict access to my protected health information to the following family member, relative, or close friend (or any other person I identify below). This includes allowing said person to pick up my hearing aid for me or know when my appointments may be. I understand that if I have a child whose parents are divorced, formal notification from the court must be provided to restrict the non-custodial parent from this information.

_____

_____

_____

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 as long as it does not contradict with the legal obligations of reporting under HIPAA (see Notice of Privacy Practices). 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.

X _____
Print Patient Name, Date
or Print Name Personal Representative, Date

X _____
Signature of patient or personal representative

See reverse for expiration/revocation statement

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

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

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 Schools for Hearing and Speech
Clarke Hearing Center
45 Round Hill Road
Northampton, MA 01060