CLARITY
MENTAL HEALTH

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

PATIENT NAME: _____DATE OF BIRTH: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone #: _____

I hereby authorize Clarity Mental Health, 595 E. Colorado Blvd, Suite 505, Pasadena, CA 91101

To release health information to:
Name: _____
Facility: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone #: _____
Fax #:_____

Records to be ___faxed, ____mailed, or ___picked up.

Date Range of Records: From: _____ To: _____

Records to include: ____Mental Health Treatment records
____Substance Use Treatment records

For the purpose of:
____ Continuation of Treatment ____ Coordination of Care ____ Application for Insurance

____ Legal ____Other (please specify: _____

*Under HIPAA, you can be charged a reasonable fee for copying records. You may also be charged for postage if you ask that records be mailed to you. HIPAA allows 30 days for a provider to respond to your request for records, with one 30-day extension for good reason.

_____ _____
Patient / Legal Representative Signature Date

_____
Relationship to Patient

Clarity Mental Health
595 E. Colorado Blvd, Suite 505, Pasadena, CA 91101
Tel: (626) 869-7338, Fax: (626) 869-7383