A.D.D. Clinic, Inc.

7381 W. Charleston Suite #130
Las Vegas NV 89117
Phone: 702.736.1919
Fax: 702.736.1016
Email: drclark@addclinic.net
Web: www.addclinic.net

AUTHORIZATION
FOR THE EXCHANGE OF PROTECTED HEALTH INFORMATION

This release authorizes the exchange of Protected Health Information pursuant to 45 CFR Parts 160 and 164.

1. The undersigned authorizes the A.D.D. Clinic, Inc. to exchange the following information: Records_____ Information_____
2. The information may be exchanged between employees of the A.D.D. Clinic, Inc. and:

Name:____
Address:____
City, State,
Zip:____
Phone/fax:____

3. The disclosure shall be made valid for the following purpose:___________.
4. This authorization will expire on (date)____________, or when (describe occurrence)____.
5. I acknowledge: I have the right to revoke this authorization at any time, and I understand that once the information is disclosed, it may no longer be protected by federal privacy law.

You may revoke this authorization only in writing sent by certified mail to the provider at the above address. The revocation will be effective only upon receipt, except (1) to the extent the Provider has acted in reliance on the authorization, or (2) the authorization was obtained as a condition of obtaining insurance coverage and the insurer wishes to use the protected health information to lawfully contest a claim.

6. I understand that treatment by the Provider is not conditioned on my signing this authorization, although exceptions will be made for (a) research-related treatment. (b) for treatment the purpose of which is creating protected health information for a third party, such as pre-employment physicals, and (c) except for psychotherapy notes, for health plans who condition enrollment or on an authorization requested prior to enrolment, or where payment is conditioned on an authorization to use PHI to determine payment.

Signed by:____Date:____________________________

Print Patient's Name:______________________________________

If person signing is other than patient, state authority under which signature is made:___________________

Witnessed by:____