CLEAR FORM

AUTHORIZATION FORM

Participant's Full Name _____ **Participant's DOB** _____

Participant's Address _____ **Participant's Phone** _____

Authorization to Disclose

1. I authorize Aviben to speak with and disclose my protected health information and other account information to the following person or entity:

   Recipient's Full Name _____ Recipient's DOB (if known) _____

   Recipient's Address _____ Recipient's Phone _____

2. The specific information that Aviben may disclose is (select one):
   - ◯ All information except psychotherapy notes
   - ◯ Specific information: _____

3. The purpose of the disclosure is (select one):
   - ◯ At my request (no specific purpose)
   - ◯ Specific purpose: _____

4. This authorization expires (select one):
   - ◯ When I no longer have an account with Aviben
   - ◯ Other: _____

Acknowledgements

- I understand that information disclosed may be subject to re-disclosure by the recipient and would then no longer be protected by HIPAA and other privacy laws. Aviben does not condition enrollment or eligibility for benefits on whether I sign this Authorization.
- I may revoke this Authorization by notifying Aviben in writing of my desire to revoke it. I understand that any action already taken in reliance on this authorization cannot be reversed and that my revocation will not affect those actions.

Signature

Participant's Signature _____ **Date** _____

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