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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

(PLEASE PRINT CLEARLY)

Name_____ Date of Birth _____
(Last) First Middle Initial (mm/dd/yyyy)

Release requested by: _____ Date: _____
(Name of client, provider or other)

Information to be released:

_____ Psychotherapy notes ONLY (Please note: If this authorization is for psychotherapy notes, you must use a separate authorization for all other types of protected health information)

_____ Other (Please describe information in detail): _____

_____

_____

Purpose of disclosure of information:

_____ My request _____ Other (please describe)_____

Person(s) authorized to make the disclosure:

_____

Person(s) authorized to receive the disclosure:

_____

Authorization will expire on: ____/____/_____ OR upon the happening of the following event that relates to me or the purpose of this disclosure of information about me:

_____

_____

Authorization and Signature: I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

Signature of patient: _____ Date:_____

Signature of guardian or personal representative: _____

Relationship to patient: _____Date:_____

PATIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time (HIPAA).

1. Tell your mental health professional if you don't understand this authorization, and they will explain it to you.
2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to your mental health professional and your insurance company, if applicable.
3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, to make payment or be eligible for benefits.
4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.
5. If this office initiated this authorization, you ***must*** receive a copy of the signed authorization.
6. ***Special instructions for completing this authorization for the use and disclosure of Psychotherapy Notes.*** HIPAA provides special protections to certain medical records known as "Psychotherapy Notes". All Psychotherapy Notes recorded on any medium (e.g. paper, electronic record)) by a mental health professional must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session, or a group, joint, or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring; (b) counseling session start and stop times; (c) the modalities and frequencies of treatment furnished; (d) the results of clinical tests; and (d) any summary of diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date.
7. In order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. ***Such authorization must be separate from an authorization to release other medical records***.