AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Client's name: _____
First Name Middle Name Last Name

Date of Birth: ___/___/___ Date authorization initiated: ___/___/___

Authorization initiated by: _____
Name (client, provider, or other)

Information to be released:

- ☐ Authorization for Psychotherapy Notes ONLY (Important: If this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected health information.)

- ☐ Circle any of the following that apply:

Intake Evaluation	Psychiatric Evaluations	Treatment Plan	Discharge Summary
Progress Notes	Psychological Evaluations	Medical Diagnosis	Medical History
Medications	Laboratory Results		

- ☐ Other (describe information in detail):_____

_____

6. Purpose of Disclosure: The reason I am authorizing release is:

- ☐ My request
- ☐ Other (describe): _____

7. Person(s) Authorized to Make the Disclosure: _____

8. Person(s) Authorized to Receive the Disclosure: _____

9. This Authorization will expire on ___/___/___ or upon the happening of the following event: _____

_____

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.

I understand that my records may contain information relating to mental health issues. I also understand that my written consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), psychiatric disorders/mental health, and/or drug and/or alcohol use. If I have been tested, diagnosed, or treated for any of these things, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment. This authorization prohibits further use or disclosure of the information being released beyond the specific limits of this consent. I understand that I may cancel this authorization at any time, except to the extent that the action has already been taken. Unless cancelled earlier by me, or specifically noted above, this authorization will expire in ninety (90) days from the signature date.

Signature of the Client: _____**Date**:_____

Signature of Personal Representative: _____**Date**:_____
Please circle: Client / Parent / Legal Guardian

CLIENT 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, make payment, or affect your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program, or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.

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 (i.e., paper, electronic) by a mental health professional (such as a psychologist or psychiatrist) 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 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 (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

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.