

Authorization for Use & Disclosure of Psychotherapy Notes

Patient Identification

Printed Name: _____ Date of Birth: _____

Address: _____

Social Security #: _____ Telephone: (____) _____

Information To Be Released – Covering the Periods of Health Care

From (date) _____ to (date) _____

Psychotherapy Notes (specify) _____

Purpose of Request

<input type="checkbox"/> Treatment or consultation	<input type="checkbox"/> At the request of the patient	<input type="checkbox"/> Billing or claims payment
<input type="checkbox"/> Treatment, payment or health care operations of [name of facility or provider]		

Other, (specify) _____

Who and Where to Send / Release Information

Name: _____

Address: _____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand if my psychotherapy notes contain information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B & C testing, and/or other sensitive information, I have been afforded the opportunity to sign a specific authorization. **Initial One: Yes** _____ **No** _____ **Not Applicable** _____

I understand if my psychotherapy notes contain information in reference to HIV/AIDS (Acquired Immunodeficiency Syndrome) testing and/or treatment I have been afforded the opportunity to sign a specific authorization.

Initial One: Yes _____ **No** _____ **Not Applicable** _____

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at [location & e-mail address]. Unless revoked, this authorization will expire on the following date or event _____ or 180 days from the date of signature.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless specified above under Purpose of Request. I can inspect or receive a copy of the protected health information to be used or disclosed.

I authorize [HOSPITAL NAME] to release the protected health information specified above.

Signature: _____ Date: _____

Authority to sign if not patient: _____

Identity of Requestor Verified via: Photo ID Matching Signature Other, specify _____

Verified by: _____