AUTHORIZATION TO USE AND DISCLOSE PSYCHOTHERAPY NOTES

Federal regulation defines Psychotherapy Notes as notes that are recorded in any medium by a mental health professional documenting or analyzing the contents of conversation during a counseling session, and that are separated from the rest of the individual's medical records. Psychotherapy notes do not include medical prescriptions, counseling session start and stop times, modalities and frequencies of treatment rendered, results of clinical tests, or summaries of diagnosis, functional status, treatment plans, symptoms, prognosis or progress.

Individual's Name: ____________________

Health Plan ID #: ____________________

Home Address: ____________________

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Home Telephone: ____________________

Date of Birth: ____________________

I authorize ____________________

to disclose my protected health information as follows:

NOTES TO BE DISCLOSED

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____

❑ Include genetic information.

RECIPIENT OF NOTES

Name: ____________________

Address: ____________________

____

REASON FOR DISCLOSURE

❑ At my request.
- or -
❑ For the following purposes: ____________________

____

____

TERM OF AUTHORIZATION

❑ Authorization will remain in effect until the ________ day of ____________ , 200___.
- or -
❑ Authorization will remain in effect until I revoke it in writing, but for no longer than 24 months from the initial date of authorization.

CONDITIONS OF AUTHORIZATION

I understand that:

✓ I may refuse to sign this authorization.

✓ I will receive a signed copy of the authorization.

✓ The information released to a third party pursuant to the authorization may no longer be covered by state and federal privacy laws.

✓ I have the right to revoke the authorization at any time, and that the revocation must be in writing.

✓ The revocation will be effective immediately upon receipt of my written notice, except that the revocation will not affect any action taken in reliance on the authorization prior to receipt of my written notice of revocation.

✓ The authorization will be maintained for a period of six (6) years or as prescribed by law.

✓ A health plan will not condition my enrollment or eligibility for health insurance benefits on my provision of the authorization, unless it requested the authorization before my enrollment solely for eligibility or enrollment determinations relating to me.

✓ A health plan may not condition payment of a claim for specified health insurance benefits on my provision of the authorization.

I have read and understood the terms of this authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. I hereby, knowingly and voluntarily, authorize the use and disclosure of my health information in the manner described above.

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Signature of Individual Date

If individual is a minor or otherwise unable to sign this authorization, the following is required:

____

Signature of Personal Representative Date

DESCRIPTION OF AUTHORITY

❑ Parent ❑ Legal Guardian* ❑ Power of Attorney*

*Documentation is required to demonstrate Legal Guardianship or Power of Attorney.