Authorization For Use or Disclosure of Psychotherapy Notes

Information

I, _____, **[Print Name of Individual (i.e., patient, resident or client)]** hereby authorize _____ **[Insert CHI Entity]** to use and/or disclose psychotherapy notes for the following patient:

Patient Name: _____ DOB: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

I authorize the following person(s) or organization to receive the information:

Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____ Email: _____

The following **psychotherapy notes** may be used and/or disclosed:

Date(s) of session(s) to be released: _____

I request the form of the information be ____ Paper ____ Electronic (CD/DVD) ____ Electronic (Email)

I authorize the release of any information contained in the above records concerning the treatment of:

- Drug or alcohol abuse;
- Drug-related conditions;
- Alcoholism;
- Psychiatric/psychological condition; Psychiatric/mental health treatment; and/or HIV-related conditions.

Reason or purpose for the use and/or disclosure of the information:

_____

Prohibition on Conditioning of Authorization: _____ will not condition treatment on your signing this authorization, unless:

- You are receiving research-related treatment; or
- The only reason the facility is providing you with health care is to make a report to a third party, such as your employer (e.g., fitness to return to work) or school (e.g., P.E. physical).

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Re-disclosure: I understand that the information used and/or disclosed according to this authorization may no longer be protected by federal privacy law (also known as HIPAA) and the recipient of your health information may potentially re-disclose it. However, under the Federal Substance Abuse Confidentiality Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

Expiration: This authorization will expire _____ (insert date, event or "once purpose stated above is served").

Revocation: I understand that I may revoke this authorization at any time by notifying _____ in writing by sending a letter to the CHI Entity specified on this release or completing the Revocation of Authorization form. I understand that if I revoke this authorization, it will not affect any actions that _____ took before it received my revocation letter. For example, _____ cannot rescind disclosures it has already made and may use my health information as necessary to bill and collect for services rendered.

This Authorization is binding: The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in the _____'s Notice of Privacy Practices.

_____

SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE DATE

Printed name of individual's personal representative, if applicable:

_____

Rationale for serving as personal representative to the individual (e.g., parent, legal guardian):

_____

FOR INTERNAL PURPOSES ONLY

When **[Insert CHI Entity]** is requesting an authorization to use health information for its own use, the following provision must be completed:

Staff Personnel:

Received by: _____ Date: _____

Was a signed copy provided to the individual? ___YES ___NO

Access approved? ___YES ___NO