AUTHORIZATION FOR USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES

This form is used to authorize the release of psychotherapy notes in accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

HIPAA provides special protections to certain health records known as "psychotherapy notes." Psychotherapy notes are defined under HIPAA as notes recorded by a healthcare 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 separated from the rest of the individual's medical record."

Excluded from the definition are the following:

- Medication prescription and monitoring.
- Counseling session start and stop times.
- The modalities and frequencies of treatment furnished.
- Any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

In order for a healthcare provider to release psychotherapy notes, the patient who is the subject of the psychotherapy notes must sign a HIPAA-compliant authorization form that specifically allows for the release of the psychotherapy notes. Such authorization must be separate from an authorization to release other health records; therefore, two authorization forms must be signed by the patient in order for the healthcare provider to release health records and psychotherapy notes.

Completion of this document authorizes the disclosure and/or use of psychotherapy notes. Failure to provide *all* information requested may invalidate this authorization.

USE AND DISCLOSURE OF PSYCHOTHERAPY NOTES

I hereby authorize _____
(Healthcare provider) (Address, street, city, state, zip code)

to release psychotherapy notes concerning me to the following recipient:

_____
(Person/Organization) (Address, street, city, state, zip code)

Patient's Initials

_____ I request that my psychotherapy notes be provided to another facility or office. I am aware of the confidentiality risks involved and release _____ (Name of healthcare provider) from responsibility for providing psychotherapy notes through fax or various media.

The following information is to be released:

a. ☐ Psychotherapy notes – Date(s) of service: _____

PURPOSE
The purpose for the release of this information is:

- ☐ Insurance or other third-party reimbursement
- ☐ Continuity of care*
- ☐ Pending legal action (attorney)
- ☐ At the request of the patient
- ☐ Other: (Specify) _____

*If for continuity of care, records needed for appointment on _____.
(Date and time)

RESTRICTIONS
I understand that if the person or entity that receives the information is not a healthcare provider or a health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I realize that the office and its employees have a responsibility to maintain the confidentiality of the health records in its possession. I understand that once the information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations. The office will not be held responsible for any subsequent disclosure by the recipient of the health information. I release _____ (Name of healthcare provider) and employees of any liability that may arise as a result of any subsequent disclosure of my health information by the recipient.

MY RIGHTS
I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.[1]

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: _____
(Name and address of practice)

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

I have a right to receive a copy of this authorization upon request.[2]

Information disclosed pursuant to this authorization could be re-disclosed by the recipient and no longer protected by the HIPAA Privacy Rule.

SIGNATURE

Patient or Legal Representative Signature/Date/Time

Print Patient's or Legal Representative's Name

Legal Representative's Relationship to Patient

Witness Signature/Date/Time

Print Witness's Name

1. If any of the HIPAA-recognized exceptions to this statement applies, this statement must be changed to describe the consequences to the individual of a refusal to sign the authorization when that covered entity can condition treatment, health plan enrollment, or benefit eligibility on the failure to obtain such authorization. A covered entity is permitted to condition treatment, health plan enrollment or benefit eligibility on the provision of an authorization as follows: (i) to conduct research-related treatment, (ii) to obtain information in connection with a health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations, or (iii) to create health information to provide to a third party or for disclosure of the health information to such third party. Under no circumstances, however, may an individual be required to authorize the disclosure of psychotherapy notes.

2. Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures.