AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

To: ____

____

____

Client: Last ________________________ First ___________________ Middle Initial ____

Client's Birth Date: _____ / _____ / _____

I, ____, hereby authorize Connie Taylor, LMFT,
(print name above)
to (check all that apply): ___ OBTAIN ___ RELEASE ___ COMMUNICATE ABOUT ___ REFERRAL

the following protected health information concerning professional services received by myself or my minor child or legal charge. It is further understood that this authorization, unless otherwise specified on this document, automatically expires one year from the signature date.

Purpose of Disclosure: The reason I am authorizing/requesting release is:

- ☐ Coordination of Care
- ☐ Evaluation of Mental Health
- ☐ Treatment
- ☐ 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.)
- ☐ Other (describe below):

____

____

I understand that information used or disclosed pursuant to the authorization/release may be subject to redisclosure by the recipient of my health information and no longer protected by the HIPAA Privacy Rule. I understand all of the aforementioned, and with informed consent and my own free will, authorize disclosure of protected health information. A copy of this release shall be as valid as the original.

Please forward any requested documentation to:
Connie Taylor, LMFT
Connie Taylor Counseling, 357 Riverside Drive, Suite 237, Franklin, TN 37064
615-545-7567
connie@connietaylorcounseling.com

Date: ________________

Client Signature: __________________________________

Signature of Parent/Guardian: _____________________ Relationship to Client: ______________

Witness Signature: ____

OFFICE USE ONLY:
Information was released/obtained on: ______________ *(Date)* *By:* __________________________ *(Provider)*

PATIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended from time to time.

1. Tell your mental health professional if you do not understand this authorization, and s/he 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 heal 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 his/her 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 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) a 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 authorization to specifically allow for release of Psychotherapy Notes. <u>Such authorization must be separate from an authorization to release other medical records.</u>