Place Patient Label Here **or**

Print Patient Name

Account Number

**Authorization for Release of Psychotherapy Notes**

(*If other types of documents are to be released, use HIPAA compliant authorization form.* ***Do not*** *use this authorization form to release documents other than psychotherapy notes*.)

1. I, ________________________________________________, hereby authorize UAMS to release to:

   Name____________________________________________________________ Phone: ______________________________

   Address:_____________________________________________________________________________________________

2. Information of:

   Patient Name______________________________________________ Medical Record No. (if known)_________________

   Date of Birth and/or Social Security No.___________________________ Phone: ___________________________________

3. Information is to be limited to the following **Dates of Treatment** (if applicable):_____________________________________

4. Information requested to be released:

   _____ Psychotherapy Notes Only.

I understand that **if** the records requested to be released include information relating to **sexually transmitted disease, AIDS or HIV, alcohol or drug use, or mental health information**, this information may be released pursuant to this authorization.

5. Purpose of access or release: _____ Medical Care _____ Insurance or Other Payment _____ At Request of the Patient
   ______ Other (explain): _____________________________________________________________________________

6. **This authorization will expire on the following date:** _________________. If no date is specified, this authorization shall expire one (1) year from the date signed below. I understand that I may revoke this authorization at any time by giving written notice to UAMS, except that a revocation of this authorization will not apply to records already released in reliance upon the authorization. A photocopy of this signed authorization shall constitute a valid authorization.

7. UAMS, its employees and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

8. I understand that once the above information is disclosed, it may be re-disclosed by the designated recipient and the information may no longer be protected by Federal privacy laws and regulations.

9. I agree to pay the copying cost, including other expenses allowed by law, such as the cost of any supplies, labor of copying, postage, or other expenses incurred by UAMS to provide the copies requested.

10. UAMS will not condition treatment, payment, enrollment or eligibility for benefits on your signing of this authorization.

Signature of Patient or Legal Representative ________________________________________________ Date: ____________________

**If Legal Representative**, authority of Legal Representative _____________________________________________________________
(such as parent of a minor, court-appointed guardian, administrator of estate of deceased, attorney-in-fact appointed with power of attorney for healthcare-related decisions, or a healthcare proxy)

_____________________________________________________________________________________________________

Approved by Originator of Psychotherapy Note or other UAMS Mental Health professional:

Print Name _______________________________________ Signature: ________________________________________