



HIPAA Authorization Form

Authorization for Use or Disclosure of Protected Health Information (PHI)

1. Print **Client's name**: _____
First Name Middle Name Last Name
2. **Date of Birth**: ____/____/____
3. **Date authorization initiated**: ____/____/____
4. Authorization initiated by: _____
Name (client, provider or other)
5. Information to be Released:
☐ 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 information in detail): _____

6. Purpose of Disclosure: The reason I am authorizing release is:
☐ My request: _____
☐ Other (describe): _____
7. Person(s) Authorized to Make the Disclosure: _____
8. Person(s) Authorized to Receive the Disclosure: _____
9. This Authorization will expire on ____/____/____ or following this event: _____

Authorization and Signature: I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

Signature of the Patient: _____ **Date:** _____

Signature of Personal Representative: _____ **Date:** _____

Relationship to Patient if Personal Representative: _____



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HIPAA Definitions and Requirements-- Explanation of Rights: Please keep for your records.

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("**HIPAA**"). This notice is effective March 31, 2012.

Tell your therapist if you don't understand this authorization, and he/she will discuss it with you.

- 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 provider at the following address:

Leslie LaRo Hayes c/o Institute for Couple and Family Enhancement
500 N. Loop 1604 East Ste. #220
San Antonio, TX 78232

- You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or 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 their practice.
- 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.**
- If we initiated this authorization, you must receive a copy of the signed authorization.

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 clinician and filed separately 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) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. To this end, it may help to consider the notes of the mental health clinician during the session as "Psychotherapy Notes" and the ongoing status and monitoring notes as "Session Notes and Summaries of Progress".

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 this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical records.