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AUTHORIZATION FOR DISCLOSURE OF PSYCHOTHERAPY NOTES

NOTE: Your protected psychotherapy notes can be disclosed only if this authorization form is completely filled out and is dated and signed. See, Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations, 45 C.F.R. §§ 164.508(b)(2)(ii), 164.501; Cal. Civil Code § 56.11, 56.05(f). This authorization is limited to disclosure of psychotherapy notes. 45 C.F.R. § 164.508(b)(3)(ii).

I, (name of patient/client) _____, authorize:

Name/Organization providing information _____

Address (optional) _____

to disclose my psychotherapy notes (as described below) to:

Name/Organization receiving information _____

Address _____

Description of the psychotherapy notes to be disclosed, including (as needed) specific identification of the notes such as type of notes, date(s) or range of dates. See, 45 C.F.R. §§ 164.508(c)(1)(i), 164.501 (definition of “psychotherapy notes”), 164.508(b)(3)(ii):

Description of each purpose for which my psychotherapy notes are to be disclosed or used (e.g. “for legal representation”). (If you choose not to provide a more specific description of the purpose, you may state “at the request of the individual” in the space below.) See, 42 C.F.R. § 164.508(c)(1)(iv), 164.501:

- I understand that if my protected health information (including psychotherapy notes) is further disclosed by the recipient of the information, it might no longer be protected under federal health information privacy regulations or California medical information privacy laws, unless it is disclosed to a health care provider or health plan. *See*, 45 C.F.R. §§ 164.508(a)(1), 164.508(c)(2)(iii), Cal. Civil Code § 56.13. However, other confidentiality requirements may protect my health information from disclosure.
- I have had the opportunity to read and consider this authorization. This authorization is voluntary on my part and has been approved by me.
- I understand that I may revoke this authorization at any time by writing to the provider(s) of the health information named above, except that I cannot revoke this authorization to the extent that any health care provider or health plan named above has taken action in reliance on this authorization. (If I am a nursing home resident, any revocation must be signed in the presence of a representative of Protection & Advocacy, Inc. in order for the revocation to be valid.)
- I understand that I have a right to receive a copy of this authorization.

A photocopy or facsimile of this authorization may be used in place of the original.

This authorization expires on _____.

Signed: _____ **Date:** _____

Name(s) of person(s) signing _____

Relationship or authority of person signing (only if signed by personal representative, e.g. parent, guardian, conservator, health care agent). *See*, 45 C.F.R. §§ 164.508(c)(1)(vi), 164.502(g): _____

Date of Birth of Patient/Client (optional, but important for identification): _____

This authorization form must be used for disclosure of psychotherapy notes by a health care provider or health plan, and for further disclosure by the recipient of those psychotherapy notes. 45 C.F.R. § 164.508(a), 150.103, 164.501; Cal. Civil Code § 56.13. “*Psychotherapy notes* means notes recorded (in any medium) 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 separated from the rest of the individual’s medical record. *Psychotherapy notes* excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.” 45 C.F.R. § 164.501.