Shawna Freshwater, Ph.D.

Authorization to use and disclose protected health information

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 (e.g. paper, electronic) by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the patient'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 session or 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) therapy 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.
* 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.

1. I am completing this form to allow the use and sharing of protected health information.

Print Name:_____
Date of Birth:_____

2. I authorize this person or organization

_____
_____

3a. To use or disclose the following information: Initial each that apply.
_____Inpatient or outpatient treatment records for physical and or psychological, psychiatric, or emotional illness or drug and/or alcohol abuse.
_____Admission and discharge summaries
_____Psychological or psychiatric evaluation(s), reports, assessments, treatment notes, summaries, or other documents with diagnoses, prognoses, recommendations, or testing records, and behavioral

observations or checklists completed by any staff member or the patient, or similar documents.
_____Treatment, recovery, rehabilitation, aftercare plans and other similar plans.
_____Social, family, educational, and vocational histories
_____Social work assessments and plans
_____Progress, nursing, case or similar notes.
_____Evaluations and reports of consultants
_____Information about how the patient's condition(s) affects or has affected his or her ability to work, and to complete tasks or activities of daily living.
_____Vocational evaluations and reports
_____Billing records
_____Academic and educational records, including achievement and other tests' results, reports of teachers' observations, and all other school or special education documents.
_____HIV-related information and drug and alcohol information contained in these records will be released under this authorization unless indicated here
_____Do not release these.
_____Complete copy of the medical record.
_____Other: _____

3b. Dates of care included: From_____to_____and
From _____ to _____ and
From _____ to _____
4. To this person or organization
_____
_____
_____
5. The information will be used/disclosed for the following purposes:
_____
6. I understand and agree that this Authorization will be valid and in effect until six (6) months from this date. I understand that after that date or event, no more of this information can be used or released to the person or organization unless I sign a new Authorization like this one.
7. I understand that I can revoke or cancel this authorization at any time by sending a letter to the Privacy Officer of the organization listed above and which is to supply this information. If I do this, it will prevent any releases after the date it is received but can not change the fact that some information may have been sent or shared before that date.
8. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the professional or facility listed nor will it affect my eligibility for benefits.

9. I understand that I may inspect and have a copy the health information described in this authorization.
10. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations.
11. I understand that this professional or facility will receive compensation for the use or disclosure of my health information.
This arrangement has been explained to me and I understand
and accept it.
12. I affirm that everything in this form that was not clear to me has been explained and I believe I now understand all of it.

_____

13. Signature of Patient

_____

Printed name of Patient

_____ Date

14. _____I acknowledge that I received a copy of this completed form.
15. I, a mental health professional, have discussed the issues above with the patient. My observations of his or her behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing
consent._____