

# Psychotherapy Notes HIPAA Authorization for Release of Information

This form authorizes the release of psychotherapy notes in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (45 CFR Â§ 164.508). Psychotherapy notes require a separate, specific authorization under HIPAA.

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## 1. Patient Information

Patient Full Name:

Date of Birth:

Phone Number:

Address:

## 2. Authorizing Provider / Entity

I hereby authorize the following individual or organization to release my psychotherapy notes:

Provider/Clinic Name:

Address:

## 3. Recipient Information

Please release and send my psychotherapy notes to:

Recipient Name/Organization:

Address:

Phone Number:

Fax Number:

## 4. Purpose of Disclosure

The purpose of this disclosure is (e.g., at the request of the individual, legal, continuing care, insurance):

## 5. Expiration of Authorization

This authorization will expire on the following date or upon the occurrence of the following specific event:

Expiration Date/Event:

## 6. Patient Rights and Acknowledgments

- I understand that psychotherapy notes are clinical notes recorded by a mental health professional documenting or analyzing the contents of conversation during a private counseling session, which are separated from the rest of my medical record.
- I understand that I have the right to revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on this authorization.
- I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.
- I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy regulations.

## 7. Signature and Date

By signing below, I acknowledge that I have read, understand, and agree to the terms of this authorization.

**Patient/Legal Representative Signature:**

**Printed Name of Legal Representative (if applicable):**

**Relationship to Patient (if applicable):**

**Date:**