The Healing Path Counseling Services

Authorization for Disclosure of Information (Consent Form)

Note: If someone other than you is paying for your treatment (e.g., parent, spouse, partner, friend, etc.), then this form MUST be completed giving consent for FINANCIAL INFORMATION to be released.

_____

Client Last Name *First Name* *Middle Initial* *Date of Birth*

_____

Mailing Address *City, State, Zip Code*

_____

Email Address *Cell Phone*

I, _____ ,

(Insert your First and Last Name above)

hereby authorize the release and disclosure of the following clinical and/or therapeutic records for the following purpose(s):

[ ] Authorization to release VERBAL information regarding counseling and therapy care and treatment:

☐ Treatment-Related Information (e.g., progress) ☐ Crisis Notification ☐ Drug/Alcohol History

☐ Financial Information (e.g., payment for services, outstanding balances, etc.)

[ ] Authorization to release PRINTED information regarding counseling and therapy care and treatment:

☐ Assessments and evaluations (specify:) ☐ Psychosocial history

☐ Entire mental health record ☐ Discharge summary ☐ Letter of Admit/Completion

☐ Summary of treatment ☐ Diagnostic Summary

☐ Other _____

to the following provider/person:

Name of Provider/Person/Payor: _____

Address: _____

Phone: _____ Fax: _____ Email:

I <u>do not</u> authorize the release of the following information:

_____

Purpose(s) for which information is to be released (check all that apply):

☐ continuity of care ☐ referral ☐ legal ☐ consultation ☐ personal ☐ financial

☐ other (please describe): _____

☐ (**CHECK BOX**) **Revocation/Expiration**: *I understand that I may revoke this authorization in writing or verbally at any time, except for actions that have already been taken prior to this request. This authorization will expire 365 days after the signature below. This agency is hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized.*

Client/Guardian's Name: _____ Signature: _____ Date: ____/____/

Witness Name: _____ Signature: _____ Date: ____/____/

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PATIENT RIGHTS AND HIPAA AUTHORIZATIONS

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").

1. Tell your counselor if you don't understand this authorization, and the counselor will explain it to you.

2. 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 (insert address of provider):

3. 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.

4. 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.

5. If this office initiated this authorization, you must receive a copy of the signed authorization.

6. 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 (such as a psychologist or psychiatrist) must be kept by the author and filed separate 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. 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.