Redefining You Therapy Authorization for Use or Disclosure of Protected Health Information

I, the undersigned, hereby authorize Redefining You Therapy to disclose the specified individually identifiable health information to and/or obtain information from the person/organization listed below. This authorization includes release of information concerning treatment and/or psychiatric/psychological conditions. The following may be released.

_____ Assessment

_____ Treatment

_____ Diagnosis

_____ Review of Records

_____ Recommendation

_____ Other, specify below

The above information is being released to/obtained from:

Name: _____

Agency: _____

Street Address: _____

City/State: _____

Telephone Number: _____

Fax Number: _____

This information is being disclosed to you from records whose confidentiality is protected by Federal Law including CFR42 and the Health Information Portability and Accountability Act (HIPPA). Federal regulations prohibit you from making further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of clinical or other information is not sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patient.

This statement must be signed and dated and may be revoked at any time except to the extent action has been taken prior to revocation in reliance upon the authorization. This consent will expire one-year from the date indicated below unless otherwise specified.

_____

I hereby state that I have read and fully understand the above statements as they apply to me. I hereby consent to the disclosure of the treatment records as indicated for the purpose and extent stated above.

_____	_____
PRINT CLIENT NAME	CLIENT/GUARDIAN SIGNATURE/DATE
_____	
SOCIAL SECURITY NUMBER	
_____	_____
PRINT WITNESS NAME	WITNESS SIGNATUE/DATE

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 mental health professional if you don't understand this authorization, and they 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 your mental health professional and your insurance company, if applicable.

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment, or affect 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 licensed clinical social worker, 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 ad 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 release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical records