Centura Health®

Patient Authorization to Disclose Psychotherapy Notes
CHCR-013 rev. 07/12

Patient Label

AUTHPHI

Patient Authorization to Disclose Psychotherapy Notes

Patient Name	Date of Birth	Last 4 of Social Security Number
Address	City, State, Zip Code	Telephone Number

I hereby authorize the Centura facility listed below to disclose/release the Protected Health Information specified in this request to the organization, agency or patient named.

Release by: _____
Centura Facility
_____
Address
_____
City, State, Zip Code
_____
HIM/Medical Records Phone and Fax Number

Release to: _____
Organization, Agency, Individual
_____
Attn:
_____
Address
_____
City, State, Zip Code

Treatment Date(s): _____
Purpose: ☐ Further Medical Care ☐ Workers' Comp
☐ Personal Use ☐ Insurance ☐ Legal
☐ Other: _____

Type of Disclosure Authorized & Delivery Instructions:
☐ Provide copies of records to organization/agency/individual
☐ Mail records directly to address above
☐ Call to pick-up records: _____
☐ Fax records to: _____

Protected Health Information Allowed to be included:
Psychotherapy Notes ONLY *(Psychotherapy Notes are 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 separated from the rest of the individual's medical record. Psychotherapy Notes exclude: medication prescription and monitoring, modalities and frequencies of treatment furnished, and results of clinical tests, and any summary of: diagnosis, functional status, treatment plan, symptoms, prognosis, progress, and progress to date.)*

Authorization: I certify that this request is made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time in writing by submitting my request in writing to the designated Health Information Management / Medical Records department. If I have authorized the disclosure of my health information to someone who is not legally required to keep it private, it may be re-disclosed and may no longer be protected. A copy or fax of this authorization will be as valid as the original.

I understand that authorizing disclosure of health information is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility to obtain benefits. I understand that I may inspect or obtain a copy of the information to be disclosed. I understand a fee may be charged for copies of my medical record. I understand the facility will provide me a copy of the signed authorization form. If I have questions about disclosure of my health information, I can contact the designated Corporate Responsibility and Privacy Officer.

Expiration: Without my express revocation, this authorization will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 90 days from the date hereof, unless a different date is specified here: _____

Acknowledgement: I understand that the information to be disclosed may include any or all information involving communicable or venereal disease, psychological or psychiatric conditions, drug or alcohol abuse and/or alcoholism. It may also include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea and human immunodeficiency viruses (HIV), also known as acquired immune deficiency syndrome (IDS).

SIGNATURE of Patient: _____ Relationship (if other than patient): _____
Patient (Parent or Legal Guardian)

Verification: ☐ Drivers License # _____ ☐ Other Appropriate ID: _____ **Date:** _____

OFFICE USE ONLY: Attach copies of required identification.

Number of pages released: _____ Completion date: _____ Delivery method: _____

Name of individual who received request: _____ Date received: _____

Patient Medical Record Number / Account Number: _____/_____

☐ **Request Approved** ☐ **Request Denied** Reason for Denial (if applicable):

PSYCHOTHERAPY NOTES PHYSICIAN APPROVAL: I am the attending physician for the above named patient. I have reviewed that medical records(s) to determine if they contain information relative to psychological or psychiatric problems which, if revealed to the patient is reasonably likely to endanger the life or physical safety of the individual or another person.

These portions of medical record(s): ☐ *May be released* ☐ *May NOT be released*

Signature of Physician or designee: _____

Print Name of Physician or designee: _____