Summit Community Care Clinic
AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION – PSYCHOTHERAPY NOTES
(HIPAA Release Form)

HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." Psychotherapy notes are defined under HIPAA as notes records by a healthcare provider who is a mental heath 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."

COMPLETE ALL SECTIONS, DATE, AND SIGN

I,_____ Date of birth _____/_____/_____ hereby voluntarily authorize the disclosure of information from my health record.

Release information **FROM**:	Release information **TO**:
Name of Facility: Address: Phone number/Fax	Name of person/organization/facility: Address: Phone Number/Fax:

The purpose or need for this disclosure is:

Further Medical Care:	Attorney:	Disability:	Personal Use:	Insurance:

Dates of Service:_____

The information to be disclosed from my health record, initial the applicable box(es) below:

Behavioral Health Clinical Summary:	Evaluations:	Treatment Plan:	Other:
Psychotherapy Notes:	Psychological/Medical Test Results:	Alcohol/Drug Abuse Treatment/Referral:	

- I understand the information to be released may include records related to behavior and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS, and genetics. This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it.
- Revocation must be made in writing to the provider/facility releasing the information. The provider/facility will not condition treatment on whether I sign the authorization.
- I may be charged for copies in accordance with state law.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law.
- This authorization will expire **one year** from the date of signing unless I indicate an earlier or later date here:_____

ATTENTION:
This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.

• If the patient is 18 years of age or older, the patient must sign and date the form.
• If the patient is 18 years of age or older and is incapable of signing, a legally authorized substitute may sign and date the form.
Please indicate your legal authority and **include written documentation of your relationship** (Circle):

Legal Guardian Conservator Health Care Agent (Health Care Power of Attorney)

• If the patient is 17 years of age or younger, the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship (circle): Parent Legal Guardian Emancipated Minor

Signature (required): _____ Date: _____/_____/_____

Printed Name (required if not patient):_____

Mailing Address of Patient:_____

SCCC Staff:_____ Date: _____/_____/_____