Black River HEALTHCARE CLINIC

MRN ______________________

FIN ______________________

PATIENT REQUESTED AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION - PSYCHOTHERAPY NOTES

HIPAA provides special protections to certain medical records known as “psychotherapy notes”. Psychotherapy notes are defined under HIPAA as notes recorded by a healthcare provider who is a mental health professional “documenting or analyzing the contents of conversation during a private health counseling session, or a group, joint, or family counseling session and that are separated from the rest of the individual’s medical record.” The following are excluded from the definition: Medication prescription and monitoring, counseling session start and stop times, modalities and frequencies of treatment furnished, and any summary of diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date.

1. ____

(Name of Patient) (Previous/Maiden Name) (Birthdate)

I authorize the use or disclosure of the above-named individual’s psychotherapy notes as described below. I understand that I have the right to refuse to sign this authorization.

2. The following individual or organization is authorized to **make the disclosure**:	**3.** The following individual or organization is authorized to **receive the disclosure via**: ☐ fax ☐ mail ☐ other
______________________ (Name of Individual or Organization receiving the info) ______________________ (Street Address) ______________________ (City, State, Zip Code)	Black River Memorial Hospital 711 West Adams Street Black River Falls, WI 54615

4. PURPOSE OF THE DISCLOSURE: List the specific purpose for requesting this information.

____

5. INFORMATION TO BE DISCLOSED: The following is a specific description of the Psychotherapy Notes I authorize to be used and/or disclosed:

____

Right to Inspect or Copy the Information to be Used or Disclosed
I understand that I have the right to inspect or copy the information used or disclosed in the authorization. In order to do so, I can contact Black River Memorial Hospital’s Privacy Officer.

Right to Receive a Copy of this Authorization
I understand that if I agree to sign this authorization, which I am not required to do, I may receive a copy of this signed authorization.

Re-disclosure of Information by Recipient
I understand that any disclosure of information pursuant to this authorization may be subject to re-disclosure by the recipient may no longer be protected by federal or state privacy regulations. If I have questions about disclosure of my health information, I can contact Black River Memorial Hospital’s Privacy Officer at 711 West Adams Street, Black River Falls, WI 54615 (715)284-5361.

OVER

MRN ____________________

FIN ____________________

Prohibition of Conditions
Black River Memorial Hospital may not condition treatment, payment, enrollment in a health plan, or eligibility for benefits based on the provision that I authorize this disclosure of my protected health information.

Right to Revoke Authorization
I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must provide the revocation in writing to Black River Memorial Hospital. I understand that the revocation will not apply to information that has already been released in response to this authorization.

6. This authorization will expire on the following date, event, or condition:

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I authorize release of my medical records in accordance with the specifications listed above. I understand written notification is necessary to cancel this request. (See **Right to Revoke Authorization**.)

A photocopy of this authorization shall be considered as valid as the original.

Employee Initiating Form: ______________________ Date/Time: ______________

☐ By checking this box, I (the patient) am requesting a copy of this authorization.

☐ Copy of Authorization given

7. Signature of patient: ______________________ Date/Time: ______________
(If signed by person other than patient, state relationship and authority to do so)

8. Witnessed by (if applicable): ______________________ Date/Time: ______________
(If you are signing as a parent of the minor patient listed above, you are declaring that your parental rights have not been terminated and you have not been denied physical placement of the child).

Patient is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased ☐ Parent of Minor

Legal Authority: ☐ Legal Guardian (Attach proof of court action)
☐ Next of Kin of Deceased (Immediate family member of deceased)

BRMH USE ONLY

Medical Records Released By: ______________________ Date/Time: ______________

Route: ☐ Mail ☐ With Patient ☐ Other ______________ ☐ Copy of authorization provided