Psychotherapy Notes Release Form

Patient's Name _____ Patient Date of Birth _____

FOR THE RELEASE OF PROTECTED MENTAL HEALTH INFORMATION

By signing this form, confidential psychotherapy notes can be released to and/or discussed with the people or agencies listed below unless noted by exclusions or limitations. Psychotherapy notes include notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a counseling session. Psychotherapy notes may not include medical records including medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. This form is signed voluntarily and may be revoked at any time. All disclosures made pursuant to this form are valid as long as they were made before the date of revocation.

Patient's Name _____ Patient Date of Birth _____

I authorize my provider to release **psychotherapy notes** to the SECOND PARTY as directed below:

Name _____

Address _____

Fax # _____Phone # _____

TYPE OF INFORMATION TO BE DISCLOSED (Initial one)

_____ I authorize that all psychotherapy notes from the date of my admission to Modern Psychiatry until today's date be released to the above-named person/organization.

_____ I authorize that only psychotherapy notes between the date range of _____ to _____ be provided.

4. My health information is being disclosed at my request or at the request of my legal guardian; or My health information is being disclosed for the following purpose:

Reason for Disclosure of Psychotherapy Notes:

_____

_____

5 LIMITATIONS: Note any exclusions or limitations here:

_____

_____

I understand that: Treatment, payment, enrollment in a health plan, or eligibility for benefits is not dependent on my signing this authorization. By signing below, I acknowledge that I have read and understand this document and that I have voluntarily given my provider authorization to disclose my psychotherapy notes. I understand that I may revoke this authorization at any time by providing a written notice to my provider, however the revocation will not have an effect on any actions taken prior to the date my revocation is received. I understand that my information may be redisclosed by the authorized person/organization receiving the information, and at that point, the information may no longer be protected under the terms of this agreement. This authorization will expire one year following the date signed unless revoked in writing.

Patient Signature_____Date* _____

Authorization is given on this patient's behalf due to being a minor or unable to sign.

Legal Guardian Signature _____ Date _____