Standard Authorization
For Disclosure of Mental Health Treatment Records

I, _____ whose Date of Birth is _____ authorize
[Insert Name of Patient/Client]

_____to disclose and/or obtain
[Insert name of practice/provider requesting records]

from _____the following checked mental
[Insert name of practice/provider you are requesting records]

health records.

Description of Information to be Disclosed

(Patient/Client should initial each item to be disclosed)

____ Assessment
____ Diagnosis
____ Psychiatric Evaluation
____ Psychosocial Evaluation
____ Psychological Evaluation
____ Progress Notes / Treatment Plan
____ Medication List
____ Presence / Participation in Treatment
____ Discharge / Admit Summary
____ Demographic Information
____ Psychotherapy Notes
____ Current Treatment Plan
____ Medical History / Information

Purpose

This information may be used or disclosed in connection with mental health treatment, payment, or healthcare operations.

If the purpose is other than as specified above, please specify: Transcranial Magnetic Stimulation Treatment

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to the requesting physician or provider. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires in 60 days from the date of signature.

Conditions

I further understand that the office / practice will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: Inability to obtain a required prior authorization from my insurance for the treatment of transcranial magnetic stimulation (TMS) and /or receive TMS treatment for my condition, or may hinder the physicians ability to fully assess my history of treatment and/or condition.

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a state law applies that is stricter than HIPAA and provides additional privacy protections.

I will be given a copy of this authorization for my records upon request.

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian, or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, legal guardian, etc.).

_____Check here if patient/client refuses to sign authorization

_____ _____

Patient Signature Date

_____ _____

Legal Guardian Date

Relationship to patient if signed by someone other than patient: _____

_____ _____

Staff / Witness Signature Date