

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Name: _____

Date of Birth: _____ Last 4 digits of SS#: _____

I hereby authorize:

Krystle Rowe, LMFT
Riverside, CA 92506
909-815-9553

to disclose or release the information stated below to :

Disclosure shall be limited to the following specific types of information which are considered instrumental in the ongoing evaluation and treatment of the individual:

I understand that I may revoke this consent at any time, except to the extent that this release has already been acted upon prior to my revocation. This consent will become null and void at the end of one year from the date of signature, or on the following date: ___/___/_____.

I am fully aware that before my records may be released, I must give my consent. Information used or disclosed under the authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Rule, but may be protected by applicable California law. I acknowledge that I may refuse to sign this release. I voluntarily and knowingly sign this consent. I understand that I have the right to request a copy of this signed release.

Signature

Date

Signature of Revocation

Signature

Date

PATIENT RIGHTS AND HIPAA AUTHORIZATIONS (Page 2 of 2)

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time (“HIPAA”).

1. Tell your mental health professional if you don't understand this authorization, and they will explain it to you.
2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to your mental health professional and your insurance company, if applicable.
3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment, or affect your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program, or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.
4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.
5. If this office initiated this authorization, you must receive a copy of the signed authorization.
6. ***Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes.*** HIPAA provides special protections to certain medical records known as “Psychotherapy Notes.” All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. “Psychotherapy Notes” are defined under HIPAA as notes 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 separate from the rest of the individual's medical records. Excluded from the “Psychotherapy Notes” definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

In order for a medical provider to release “Psychotherapy Notes” to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical records.