



☎ 203-383-3061

✉ Info@depressionandanxietyrelief.com

Date: _____

Psychotherapy Notes Release (HIPAA)

Patient full name: _____

Date of birth: _____

Email: _____

Phone: _____

Release psychotherapy notes to: _____

Recipient address / email / fax: _____

Limits on release: _____

Purpose: _____

HIPAA PSYCHOTHERAPY NOTES RELEASE FORM

This form authorizes the release of your psychiatric, psychological, and psychotherapy notes (collectively referred to as "Psychotherapy Notes"). Psychotherapy Notes are special notes your provider makes during your sessions. These types of notes capture the provider's impressions about you and contain details of your conversations. These notes are often kept separate from your medical record because they contain sensitive information relevant to no one other than your provider. Accordingly, these notes are given extra protection under HIPAA laws. Because of this, we need your specific and separate written permission to share these notes, even if you have already signed a release for other parts of your medical record. You are not required to sign this form, and your decision will not affect your treatment. Please complete all sections of this form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.

Patient Information

Authorized Party

I, the Patient named above, give permission to the following "Authorized Party" to release my Psychotherapy Notes in accordance with the terms of this Release Form:

Disclosure

I, the Patient named above, give permission to the Authorized Party to release my Psychotherapy Notes to the following party:

I give permission to the party described above to receive my Psychotherapy Notes as described in this Authorization form. I understand that the person(s)/organization(s) listed above may not be covered by state and/or federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

Method of Disclosure

I, the Patient named above, give permission to the Authorized Party to disclose my Psychotherapy Notes via the following methods (check all that apply):

(*note that email may not be a secure method of communication)

I authorize release of my Psychotherapy Notes in the following formats (select all that apply):

Electronic copy or access via web portal

🌐 www.depressionandanxietyrelief.com

📍 2389 Main St., Suite 100 Glastonbury, CT 06033

Date: _____

Hard Copies**Psychotherapy Notes Acknowledgment**

By initialing, you are giving permission to the Authorized Party to disclose your Psychotherapy Notes in accordance with the terms of this release form. You also acknowledge and understand that Psychotherapy Notes are special notes your therapist makes during your sessions and they are given extra protection under HIPAA laws. You understand that your Psychotherapy Notes may include and contain information about you with respect to the following conditions:

- Substance use disorder diagnosis or treatment
- Mental health
- Sexually transmitted disease (including HIV/AIDS)
- Reproductive health (including contraception, prenatal care and abortion)
- General medical and dental health
- Domestic abuse
- Any treatment that may have been given by other health care providers

Dates

I, the Patient described above, would like the Psychotherapy Notes described above to be released for the following dates (select one):

All dates

Only those records from the start date of: ____/____/____ to the end date of: ____/____/____

Purpose

The reason for disclosure of the Psychotherapy Notes is (select all that apply):

At the patient's Employment Disability request Legal purposes determination To receive payment Personal use Other (specify):

School**Termination**

This authorization will terminate (choose one):

Upon sending a written notice of revocation to the Authorized Party**Revocation**

I, the Patient described above, understand that I have the right to revoke this Authorization any time. If I revoke this Authorization, I understand that I must do so in writing at the Authorized Party's address as listed on page one of this Authorization. I understand that the revocation will not apply to information that has already been released in response to this Authorization. I understand that the revocation will not apply to my insurance company, Medicaid, and Medicare.

Acknowledgment of Rights

By signing this Authorization form, I, the Patient described above, understand that:

- a. I have the right to revoke this Authorization, in writing at any time, except where uses or disclosures have already been made based upon my original permission.

Date: _____

- b. Uses and disclosures already made based upon my original permission cannot be taken back.
- c. Once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
- d. Completing this Authorization form is voluntary and that treatment will not be denied if I refuse to sign this form.
- e. I will receive a copy of this Authorization after I have signed it.
- f. I may inspect or copy the information to be used or disclosed.
- g. A copy of this Authorization is as valid as the original.
- h. My treatment, payment, enrollment, and/or eligibility or benefits is NOT in any way conditioned upon nor will be affected by my signing or refusal to sign this form.

I certify that I have read and fully understand the statements above on all pages and I consent fully and voluntarily to its contents. By signing below, I authorize the release of my Psychotherapy Notes in accordance with the terms of this release form.

* If patient is unable to sign on behalf of self, then complete the following section:

(e.g., parent, spouse, representative, guardian, etc.)

Reason: Minor Incapacitated

* If you are a legal representative of the person whose information you are requesting, you must provide documentation proving your valid legal authority to request this information (e.g., power of attorney, healthcare surrogate form, court order, appointment of a guardianship, order appointing personal representative, letter of administration, etc.).

Witness

Patient signature: _____ Date: _____