TheraThrive
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# AUTHORIZATION TO USE OR DISCLOSE HEALTH CARE INFORMATION



Completion of this document authorizes the disclosure of individually identifiable health information, as set forth below, consistent with California and Federal Law concerning the privacy of such information.

Client's Full Name: _____

Client's Date of Birth:_____

Date authorization initialized: _____

Authorization initiated by:_____
Client, Provider, Other (Name)

I request and authorize the professionals and staff at TheraThrive to release the health care information described below. This information should only be released to:

Name: _____

Phone#: _____ Fax#: _____

Please initial to specifically authorize the use and/or disclosure of:

_____Verbal Discussion of Case

_____Hospital/Emergency Room Records

_____Invoicing/Billing Statements

_____Other:_____
(Specify)

_____Psychological Assessment/Test Records

_____Psychotherapy Notes (*Important*: If this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected health information.

This authorization shall remain in effect until (check one):

- ❑ Treatment has been terminated
- ❑ Date: _____
- ❑ Event: _____
  (fill in an event that relates to the individual or the purpose of the use or disclosure)

After this expiration my therapist can no longer use or disclose my protected health information without first obtaining a new authorization form.

I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

Signature of Client or Personal Representative: _____

Printed Name of Client or Personal Representatives: _____

Authorization To Use Or Disclose Health Care Information:
CLIENT RIGHTS AND HIPAA AUTHORIZATIONS
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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(s) if you don't understand this authorization, and he/she (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 Licensed Professional Clinical Counselor, 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 counselling 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 (3) 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.