Huntington Beach
5011 Argosy Avenue, Suite 9
Huntington Beach, CA 92649

Fullerton
285 Imperial Hwy. Suite 104
Fullerton, CA 92835

Authorization for Use or Disclosure of Protected Health Information

Client Information

Name:_____Birth date:_____/_____/ _____
(Last) (First) (Middle Initial)

Address: _____
(Street and Number, City, State, Zip)

Phone:(____)_____-_____E-mail:_____

Description of information (Check all that apply)

- ☐ Assessment/Evaluation
- ☐ Diagnosis
- ☐ Entire Medical Record - Only Released to a 3rd Party (Lawyer, Physician, etc.)
- ☐ Other (Specify):_____
- ☐ Results of Psychological Tests
- ☐ Discharge Summary
- ☐ Treatment Plan History
- ☐ Psychotherapy Notes - Only Released to a 3rd Party (Lawyer, Physician, etc.)
- ☐ Medication History/Current

Purpose of Disclosure (Check all that apply)

- ☐ Further mental health care
- ☐ Applying for insurance
- ☐ At the request of the individual
- ☐ Payment of insurance claim
- ☐ Vocational rehab, evaluation
- ☐ Legal investigation
- ☐ Disability determination
- ☐ Other (specify): _____

Recipient Information

I,_____, do hereby authorize CAV Family Therapy, Inc.:

(Check all that apply)

- ☐ To release my information to the person or facility below.
- ☐ To receive my information from the person or facility below.

Name of person/facility releasing/receiving information: _____

Phone: (____)_____-_____

Address: _____
(Street and Number, City, State, Zip)

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Date of Authorization:_____/_____/ _____

Authorization to expire on:_____/_____/ _____
or upon the happening of the following event: _____

Authorization and Signature

I authorize the release of my confidential protected health information, as described in my directions above. 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 (client) Date

If signed by a personal representative:

(a) Print your name: _____

(b) Indicate your relationship to the client and/or reason and legal authority for signing:

Client is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased

Legal authority: ☐ Parent ☐ Legal Guardian ☐ Representative of Decease

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PATIENT RIGHTS AND HIPAA AUTHORIZATIONS

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 do not 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 that the 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. <u>Such an authorization must be separate from an authorization to release other medical records.</u>