AUTHORIZATION FOR RELEASE OF PROTECTED PSYCHOTHERAPY NOTES

My Notice of Privacy Protection provides information about how I may use and disclose protected health information (PHI) about you. On occasion, you (the patient) and / or I may want to use PHI for reasons other than treatment, payment, and health operations, or for other purposes permitted by law. The Health Insurance Portability and Accountability Act of 1996 provides special protections to certain medical records known as "psychotherapy notes". Psychotherapy notes are defined under HIPAA as notes recorded by a health 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 separated from the rest of the individual's medical record".

In order for a medical provider to release psychotherapy notes to an attorney or other third party, the patient or designated guardian who is the subject of the psychotherapy notes must sign a HIPAA-compliant authorization form that specifically allows for the release of the psychotherapy notes. Such authorization must be separate from an authorization to release other medical records. Therefore two authorization forms must be signed by the patient in order for the provider to release both the medical records and the psychotherapy notes.

Completion of this document authorizes the disclosure and/or use of psychotherapy notes. Failure to provide *all* information requested may invalidate this authorization. This form summarizes the anticipated use of information about you for which this authorization is required.

I hereby authorize the following mental health professional to release my psychotherapy notes:

Richard Gottlieb, M.D., Psy.D.
14354 N. Frank Lloyd Wright Blvd. Suite 20
Scottsdale, AZ 85260

I authorize my psychotherapy notes to be released to the following person/organization:

_____ (Person/Organization)

_____(Address)

_____(City, State, Zip)

I request Dr. Gottlieb to fax my records to the following fax number, and I am fully aware that there may be a loss of confidentiality should the psychotherapy notes be received by someone other than the intended recipient and that the above mentioned Protected Health Information may be subject to re-disclosure by the party receiving the information and may no longer be protected by the privacy rules.

_____ (Fax Number)

Specific description of the information to be used or disclosed, including the specific purpose:

_____

_____

_____

Expiration date of this authorization: _____

To the extent that this form authorizes the sale of your Protected Health Information, such a disclosure will result in remuneration to me.

By signing this form, you authorize me to use and disclose Protected Health Information about you for the reasons mentioned above. You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures I have already made in reliance on your prior authorization. I am the Privacy Officer of my practice, and so in such a case you will need to submit your revocation in writing to me.

This authorization was signed by:

Patient's Name: _____ DOB: _____

Patient's Representative: _____ Date signed: _____

Representative's relationship to Patient: _____

Witness: _____ Date signed: _____