Noemi A. Bolton, MSSN, MSW, LCSW
Psychotherapy for Individuals, Couples, Families & Groups

24 Mine Street, Suite 2D, Flemington, NJ 08822 | Web: www.noemibolton.com | Phone: (908) 246-7489 | Fax: (908) 806-2379

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Client's Name & Information			
1.	Last Name:	First Name:	Middle Initial:
2.	Birth Date (mm/dd/yyyy):		
3.	Date Authorization Initiated (mm/dd/yyyy):		
4.	Authorization Initiated by: (Enter name of Client, Provider or other)		
5.	Information to be Released: ☐ Authorization for Psychotherapy Notes **ONLY** (Important: If this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected health information.) ☐ Other (Describe information in detail): ______________________		
6.	Purpose of Disclosure: The reason I am authorizing release is: ☐ My request ☐ Other (describe): ______________________		
7.	Person(s) Authorized to Make the Disclosure:		
8.	Person(s) Authorized to Receive the Disclosure:		
9.	This Authorization will expire on __/__/____ or upon the occurrence 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.

______________________________ ______________________

Client Signature **Date of Signature**

______________________________ ______________________

Client's Parent/Guardian Signature (if under age 18) **Date of Signature**

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If Guardian, Relationship to Client

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CLIENT RIGHTS AND HIPAA AUTHORIZATIONS

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

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 release 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 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 an information release 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 **<u>must</u>** receive a copy of the signed authorization.

6. **Special Instructions for completing an 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 authorization must be separate from an authorization to release other medical records</u>.**