



## **Patient / Client Rights and HIPAA Authorizations** **(Page 1 of 2)**

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 don’t 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 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 authorization 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 “Psychotherapy Notes”. All Psychotherapy Notes recorded on any medium (i.e. paper, electronic) by mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separated 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 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. Such authorization must be separate from an authorization to release other medical records.



**AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION  
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Client's Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date Authorization Initiated: \_\_\_\_/\_\_\_\_/\_\_\_\_

Authorization Initiated By: \_\_\_\_\_  
Name (client, provider, or other)

**Information to be released:**

Authorization for Psychotherapy Note 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.)

Authorization for Crystal Hollenbeck to discuss all aspects of my treatment with the following person(s):

\_\_\_\_\_

Other (describe information in detail): \_\_\_\_\_

**Purpose of Disclosure:** The reason I am authorizing release is:

My Request       Other (describe): \_\_\_\_\_

**I authorize the following** person or organization (name and address)

To Release Information To and/or  To Obtain Information From Crystal Hollenbeck, EdD, LMHC

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ State \_\_\_\_\_ Zipcode \_\_\_\_\_

**This Authorization will expire on** \_\_\_\_/\_\_\_\_/\_\_\_\_, or upon my written request.

**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 of the Client: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Personal Representative: \_\_\_\_\_

Relationship to Client of Personal Representative: \_\_\_\_\_