AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION – PSYCHOTHERAPY NOTES ONLY

1. Client's name: _____
   First Middle Last

2. Date of Birth: __ _/__ _/_ __

3. Authorization requested by: *Kathryn Montgomery, MA, LPC, NCC, CHT*_ _____
   Requestor

5. I authorize Requestor to request and/or disclose the following types of information:
   _____ Psychotherapy Notes Only

6. My purpose for granting this authorization is:
   _____ My request
   _____ Other (describe): _____

7. Person(s) or organization(s) authorized to release and/or disclose information to Requestor:
   _____
   _____
   _____

8. This Authorization will expire one year from today's date on ___/___/___ *or* upon the following event: _____.
   I authorize the release of my confidential protected health information, as described above. I understand that this authorization is voluntary, the information to be disclosed is protected by law, and its use and disclosure must conform to that law and limits described herein.

I understand that I can rescind my authorization for release at any time by notifying the Requestor in writing and that such revocation is effective only after its receipt by Requestor. I understand that any use of information disclosure made prior to such revocation will not be affected by the revocation.

I authorize a photocopy of this page of this two-page document to be treated as an original when attached to a letter or FAX requesting confidential information as described above.

I have received the second page of this two-page document describing my rights in relation to this authorization.

_____
Printed Name of Client (and Personal Representative if applicable)

_____
Signature of Client (or Personal Representative if applicable)

_____
Date of signature:

HIPAA: PATIENT RIGHTS AND AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

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 counselor if you don't understand this authorization, and the counselor 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 provider at the following address:

   Kathryn Montgomery, MA, LPC, NCC, CHT
   5460 Ward Road – Suite 210
   Arvada, CO 80002-1806

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain any treatment or payment or 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 does have 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. Since such authorization must be separate from an authorization to release other medical records, you may be required to sign a separate Authorization for Medical Records if your treatment so warrants.