

AUTHORIZATON FOR MUTUAL RELEASE OF CLIENT INFORMATION

CLIENT NAME (PRINT) _____

I request that information my current and/or past diagnoses, medication, therapy, treatment, insurance status, billing , payment or other purpose (fill in here _____) be exchanged verbally and /or in writing between my psychologist, Gail Kalin, Ph.D (Licensed Clinical Psychologist) and the following:

Name and Title _____

Relationship to you: _____
(e.g. psychiatrist, previous therapist, family member, attorney, insurance, etc.)

Address: _____

Phone: _____ Year(s) of Treatment _____

Fax: _____ Email: _____

In authorizing this mutual disclosure, I understand this information will be used solely for the purposes of my treatment, evaluation, payment or _____ (fill in if other), both now and in the future.

I understand that I have the right to meet with my clinician to inspect my mental health information record.

I further understand that this information cannot be re-disclosed without my authorization and that the law requires the following notice:

The unauthorized disclosure of mental health information violates the provisions of the District of Columbia Mental health Information Act of 1978. Disclosures may only be made pursuant to a valid authorization by the client or as provided in Titles III or IV of that Act. The Act provides for civil damages and criminal Penalties for violations.

This consent is subject to revocation in writing at any time.

CLIENT SIGNATURE: _____ DATE: _____

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 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 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. Such authorization must be separate from an authorization to release other medical records.

Client Name _____

Client Signature _____

Date _____