Atrium Health

Authorization for Release of Health Information – Psychotherapy Notes

I hereby authorize the use or disclosure of my identifiable health information as described below. I understand that if the organization authorized to receive the information is not an insurance company or healthcare provider, the released information may no longer be protected by federal privacy regulations.

Patient Name: _____
First Middle / Maiden Last

Social Security #: _____ **Date of Birth:** _____

The following individual / organization is authorized to release the requested health information:

Name: _____ **Address:** _____

Telephone Number: _____ _____

Please note the date(s) of service for Psychotherapy Notes being requested:

From: _____ **To:** _____

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).

This information may be released to and used by the following individual / organization:

Name: _____ **Address:** _____

Telephone Number: _____ _____

Will the healthcare provider requesting the authorization receive any financial or in-kind compensation in exchange for using or disclosing the health information described above? ❑ Yes ❑ No

Purpose of Disclosure:

❑ Medical Review ❑ Legal Review ❑ Insurance Review ❑ Personal Use ❑ Other _____

I understand that I have a right to revoke this authorization at any time by notifying the Medical Record Department of the providing organization in writing. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that authorizing the disclosure of this private health information is voluntary. I can refuse to sign this authorization. This authorization will expire when the information from the event/purpose noted above is released to the recipient named in this document.

Printed Name: _____ **Signature:** _____ **Date:** _____
(Patient / Authorized Representative)

If Authorized Representative, please indicate relationship to patient:
❑ Spouse
❑ Parent
❑ Other _____
*Please note, if information relating to the treatment of drug or alcohol abuse is being released for a patient under the age of 18, the patient must also sign this authorization. **Signature of Minor:** _____

FOR ATRIUM HEALTH USE ONLY

❑ Identification verified ❑ Copy of Authorization given to patient **Medical Record #:** _____

AH Employee:_____ Patient Addressograph / Label
Signature / Title / Date