Brenda Diller dba
Avelon B McNae, MHR, CHT, HTP
5554 S Prince Street, Suite 219
Littleton, Colorado 80120
www.AvelonBMcNae.com
AvelonBMcNae@gmail.com
Office: 970-422-6102
Secure Fax: 970-422-7096

Authorization to Release Confidential Protected Health Information

Name: _____
First Middle Last

Address: _____
Number & Street City State Zip Code

Date of Birth: ____/____/_____

Date of Authorization: ____/_____/_____

Person Requesting Authorization: _____

Requested information to be released: _____
_____

Note: If this authorization is for psychotherapy notes only, it cannot be used for any other form of authorization. A separate authorization may be used for other purposes.

Reason for disclosure: _____
_____
_____

Who is authorized to make this disclosure? _____

Who is authorized to receive this disclosure?_____

Authorization & Signature: I am authorizing, _____ to release my confidential, protected health care information to _____ according to my instructions above. This is my voluntary authorization and I understand the information I am authorizing to be disclosed is protected healthcare information according to HIPAA laws. The person I am authorizing this protected healthcare information may redisclose it to another source unless prohibited by state laws, which limit or prohibit further the subsequent use or redisclosure of my confidential, protected healthcare information.

Signature of Client:_____

Signature of Personal Representative or Agent:_____

Relationship to Client of Personal Representative or Agent:_____

Date of Signature:_____

Client Rights & HIPAA Authorization to Release Confidential, Protected Healthcare Information

Your rights regarding this authorization are specified in the Health Insurance Portability Act and Accountability Act of 1996 "HIPAA."

If you do not understand this authorization, please inform your mental health professional and ask for further clarification.

You have the right to cancel and revoke this authorization at anytime, except under the following conditions: (a) to any extent that information has already been shared based on your authorization, or (b) you gave this authorization as a condition of obtaining insurance coverage. You must submit your revocation or cancellation of this authorization in writing to your mental health professional and if applicable to your insurance company.

You have the right to refuse to sign this authorization. Doing so will not affect your right to receive mental healthcare, to make payments, or your benefits eligibility for insurance. Your mental health professional has the right to refuse treatment if you refuse to sign this authorization if you are part of a research-related treatment program, or if you authorized your provider to disclose your protected healthcare information to a third party.

Once information about you is disclosed according to your instructions herein, this office has no control over how it may be disclosed by the recipient. At this point your information may no longer be protected by HIPAA.

If this office initiated the authorization, you must receive a copy of the signed authorization.

For the use of authorization for disclosure of psychotherapy notes:
HIPAA provides protection for certain medical records known as psychotherapy notes. All psychotherapy notes recorded on any medium, (paper or electronic) by a mental health professional must be kept by the author and filed separately from other healthcare records to maintain higher protection standards. Psychotherapy notes are defined by HIPAA as notes recorded by a healthcare provider being a mental health professional who documents or analyzes contents of psychotherapy sessions, which are separate from the rest of the client's medical records. The following are excluded from the 'psychotherapy notes' definition: (a) the monitoring of medication and prescriptions (b) start and stop times of psychotherapy sessions (c) the modalities and frequencies of psychotherapy (d) results of clinical tests (e) summaries of: diagnosis, status of function, treatment plans, symptoms, prognosis, and progress to date.

For a mental health professional to release psychotherapy notes to a third party, the client who is the subject of the psychotherapy notes must sign this authorization to specifically give permission to release the psychotherapy notes. This authorization must be separate from any other authorization to release other client medical records.