Authorization for Use and/or Disclosure of Psychotherapy Notes

MEDICAL RECORD #: _____

Psychotherapy Notes include notes recorded (in any medium) 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 separated from the rest of the patient's medical record. Psychotherapy Notes excludes medication prescription and monitoring, counseling session start and stop time, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

PATIENT INFORMATION (Please Print)

Last Name | First Name | Middle Initial | Maiden Name (if applicable) | Gender

Address | City | State | Zip Code | Phone Number

Date of Birth | Social Security Number | Email Address (optional)

Dates of Treatment/Particular Illness/Admission Requested: _____

☐ All Psychotherapy Notes ☐ Other _____ ☐ Other _____

Purpose for Disclosure

☐ Treatment ☐ Personal ☐ Other _____
☐ Attorney/Legal ☐ Research
☐ Education ☐ Other _____

Disclose Records To:	
Name	
Organization/Company	
Title	
Street Address	
City, State, Zip	
Telephone Number	

Information May Be: ☐ Mailed ☐ Picked Up By whom: _____
☐ Reviewed Only ☐ In-Person Meeting

This Authorization will expire 60 days after the date below, or sooner by my choice, in which case, Authorization will expire on _____, or _____ (event) occurs. This Authorization may be revoked at any time to the extent that use and/or disclosure has not already occurred prior to your request for revocation. In order to revoke the Authorization the individual/parent/legal guardian must submit a revocation request in writing to the Health Information Management department, 636 – 8233. Please refer to Cincinnati Children's Hospital Medical Center's (CCHMC) Notice of Privacy Practices.

CCHMC will not condition treatment, payment, enrollment or eligibility for benefits on the execution of this Authorization. The information used or disclosed as a result of this Authorization may be subject to redisclosure by the person or entity receiving such information, and thus no longer protected by the federal privacy regulations. I understand that a standardized fee has been established for copies of medical records. Please inquire regarding these fees prior to requesting copies.

I, the undersigned, hereby authorize Cincinnati Children's Hospital Medical Center to use and/or disclose information from my (or give relationship) _____ medical or financial record as specified above. This authorization includes the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions to the above mentioned entity(s).

Signature: **Date:** ☐ **Patient** ☐ **Parent** ☐ **Legal Guardian***

The above statements must be signed and dated to be valid. If the patient is an emancipated minor or 18 years of age, he/she is required to sign the Authorization. If CCHMC requests this Authorization for its own use or disclosure, a copy of this Authorization must be provided to the individual completing this form.

Documentation regarding guardianship must be provided in order to comply with the above request.

Request Has Been Fulfilled: ☐ **Yes, Initials _____ Date _____**