

AUTHORIZATION TO DISCLOSE PSYCHOTHERAPY NOTES

PATIENT NAME: _____ DATE OF BIRTH: _____
[Please print full name]

SOCIAL SECURITY NUMBER: _____ DAY PHONE: _____

Psychotherapy Note Information Requested: (Complete options below)

Date(s) of Service Requested: _____

Person/Facility to Receive Information: _____

Method of Release:

Mailed to: STREET: _____ CITY: _____ STATE: _____ ZIP: _____

Health Care Provider Fax Number (Continuity of Care only): _____

Patient Email Address (Patient requests only): _____

Purpose of Disclosure:

Continuity of Care
 Insurance
 Litigation
 Worker's Compensation
 Disability Determination
 Personal
 Other (Please specify): _____

Authorization to Release Information:

1. I understand that, by signing this Authorization to Disclose Health Information, I am giving my permission for WVU Physicians of Charleston to disclose psychotherapy notes as defined in the Health Insurance Portability and Accountability Act (HIPAA) for all dates of service as specified above.

Other Special Instructions, if any: _____

2. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment, payment, enrollment in a health plan, or eligibility for benefits. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact 304-341-1550

3. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to: Director of Health Information Management, WVUPC, 3110 MacCorkle Avenue, SE, Charleston, West Virginia 25304. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire 180 days from the date of signature. If applicable, insert another date or event of expiration:

4. I understand that I will be given a copy of this authorization form upon request. Furthermore, I understand that copying charges will be applied according to State/Federal Law.

Signature of Patient or Legal Representative _____ DATE _____

If signed by legal representative, relationship to patient: _____

For Provider Use Only	Provider Signature _____ Date _____
<input type="checkbox"/> Approve	Provider Notes _____
<input type="checkbox"/> Deny	_____

