



**AUTHORIZATION FOR RELEASE  
OF  
PSYCHOTHERAPY NOTES**

NAME OF PATIENT	
DATE OF BIRTH	
ADDRESS	CITY/STATE/ ZIP

- I hereby voluntarily authorize \_\_\_\_\_ to disclose any psychotherapy notes that may be in my medical files to \_\_\_\_\_.
- The purpose for this disclosure is for \_\_\_\_\_.
- This authorization shall become effective immediately and shall remain in effect until \_\_\_\_\_ (date) or for one year from the date of signature if no date is entered.

I understand that I may revoke this authorization in writing at any time prior to the release of information from DPH, and that revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

I understand that my eligibility for benefits, treatment or payment is not conditioned upon my provision of this authorization.

I understand that information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act.

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Print Authorized Representative's Name (if applicable)

\_\_\_\_\_  
Authorized Representative's Signature (if applicable)

\_\_\_\_\_  
Date

*\*Psychotherapy notes* means 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 separated from the rest of the individual's medical record. 45 C.F.R. 164.501.