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CLIENT AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Client's name: ____

Date of signed authorization: ___________________________

Authorization requested by: ___ Client ___ Other: ______________________________

I/We ____
hereby authorize my therapist, Carolyn E. Taylor, to disclose clinical information to the extent necessary to accomplish my purpose and benefit through such exchange with the following individual or agency:

Name ____

Address ____

City ____ State _____ Zip Code ___________

Telephone: ____________________________ Fax: ______________________________

This authorization shall remain valid until: _________________________________
(An ending date or event is required. Authorization is typically granted for a one year at a time.)

I understand that this authorization is voluntary, that it is solely for the purpose of furthering or coordinating treatment, that a photocopy of this authorization shall be considered as effective and valid as the original, that I have a right to receive a copy of this authorization, and that information disclosed in accord with this authorization may be re-disclosed by the recipient. I understand that I may cancel this authorization, but that any cancellation or modification must be in writing. This disclosure of information is authorized for the following purpose:

____

____

Authorizing Signature(s): ____

____

Authorized Signature: ____
Carolyn E. Taylor, LMFT

CLIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the 1996 Health Insurance Portability and Accountability Act ("HIPAA"), as amended from time to time.

1. Tell your mental health professional if you don't understand this authorization, and they will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to your mental health professional and your insurance company, if applicable.

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment, or affect your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program, or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.

5. If this office (rather than you) initiated this authorization, you must receive a copy of the signed authorization.

6. Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes. HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a healthcare 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 separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

In order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical records or to make verbal disclosures.