Beacon Pediatric
BEHAVIORAL HEALTH

Authorization for Disclosure or Release of Protected Health Information

I, _____ (legal guardian/adult client) hereby authorize _____ ("Provider") at Beacon Pediatric Behavioral Health to ☐ disclose and/or ☐ receive information (as indicated below) regarding _____(client name) (DOB: ___/___/___), ☐ to and/or ☐ from:

Name of person or facility: _____ Address: _____

Method of exchange: I consent to the exchange of information via:

☐ *Phone: _____ ☐ *Fax: _____ ☐ *Email: _____

☐ In person communication ☐ *Written communication ☐ Other: _____

By authorizing this release, you acknowledge and accept that any method of electronic or postal transmission carries the possible threat of interception or unintentional misdirection of information.

Purpose of disclosure: This disclosure of information or records is required for the following purpose(s):

☐ Treatment Planning ☐ Evaluation ☐ Consultation with health professionals

☐ Consultation with school staff ☐ Observation of client ☐ Other: _____

Information to be released:

☐ Authorization for specific portion of client record (describe): _____

☐ Authorization for summary of services/clinical conclusions (if available)

☐ Authorization for Psychotherapy Notes ONLY*

☐ Communication with individual(s) identified above for purpose(s) identified above (***not*** including records)

☐ Consent is for observation of client in school/community setting

☐ Other (describe in detail): _____

** Psychotherapy notes have increased protection under HIPPA; an individual authorization is required,* ***separate*** *from an authorization for any other type of protected health information*

NOTE: PLEASE ALLOW 5-10 BUSINESS DAYS FOR PREPARATION AND SUBMISSION OF ANY REQUESTED RECORDS. THANK YOU!

Limitations: The specific uses and limitations of the types of medical information to be discussed are as follows:

_____

Authorization and Signature:

I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, and I have the right to refuse to sign this form. I understand that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information. I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules. I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing, and after 1 year this authorization automatically expires. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. I have been informed of what information will be given, its purpose, and the recipient.

After 1 year this authorization automatically expires. Or this authorization will expire on ___/___/___ or upon the happening of the following event (whichever comes first): _____

Signature of Client/Legal Guardian/Parent: _____ **Date**: _____

PATIENT RIGHTS AND HIPAA AUTHORIZATIONS

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

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 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 (such as a psychologist or psychiatrist) 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 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 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.

CLIENT NAME: _____