Site contact information

# Authorization for Release of Psychotherapy Notes

**PATIENT AND PROVIDER/FACILITY INFORMATION:**

Name ________________________________________ DOB ________________ SSN ______________________

Address__________________________________________________________ Phone ____________________

I authorize Valley Health to (select one): ◯ release information to ◯ receive information from

"Self" **OR** Name of provider/facility ________________________________________ Phone ___________________

Address______________________________________________________________ Fax ____________________

◯ Release information to MyChart (*****ONLY*** *if patient is releasing records to self*)*

**TIMEFRAME & PURPOSE OF INFORMATION TO BE RELEASED:**
**List specific dates/years ("all" is not permitted; must be filled in):** ________________________________________

If you only want a certain clinician's records released rather than all, list the name here: _______________________

**Purpose of Disclosure:** ◯ continuity of care ◯ changing clinicians ◯ consultation/second opinion ◯ insurance

◯ disability ◯ school ◯ legal ◯ personal ◯ other (must specify): ________________________________________

****BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE FOLLOWING**:**

1. I understand my psychotherapy notes may include sensitive information such as reference to substance use and substance use disorder, STD/communicable disease, HIV, and genetic testing. If I wish to exclude any of this information from release, I must specify below:
   Specific information **NOT** to be released: ______________________________________________________
2. This authorization will expire 1 year after I have signed this form.
3. I may revoke this authorization at any time by notifying the providing organization in writing. My notification will be effective on the day it is received except to the extent action has already been taken on the original request.
4. The information used before this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.
5. Valley Health may not condition treatment or payment on whether I sign this authorization.
6. If I receive substance use disorder treatment services, including the MAT program at Valley Health, such information is protected under 42 CFR Part 2.

**Signature of patient/legal guardian/representative**: _________________________________ Date _____________

Relationship if not patient: __________________________________________________________________________

*(*If patient is deceased – must provide documentation of MPOA or Administrator/Executor of Estate*)*

Witness signature: ____________________________________________________________ Date _____________