

CHARIS Counseling Associates  
11802 NE 117<sup>th</sup> Ave  
Vancouver, WA 98662  
360-891-2000

### AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, \_\_\_\_\_, hereby authorize  
*First Middle Last*  
\_\_\_\_\_ of CHARIS Counseling Associates to mutually  
*name of counselor*  
share verbal and/or written communication with (*name, title, business, address, phone number, fax*):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

any and all information indicated below (*please INITIAL each that applies*):

\_\_\_\_\_ Authorization for Psychotherapy Notes **ONLY** (*Important: If this authorization is for Psychotherapy Notes, you must NOT use it as an authorization for any other type of protected health information.*)

\_\_\_\_\_ Session Notes    \_\_\_\_\_ Evaluation/Assessment    \_\_\_\_\_ Treatment Plan    \_\_\_\_\_ Treatment Summary

\_\_\_\_\_ Discharge Summary    \_\_\_\_\_ Diagnoses    \_\_\_\_\_ Drug and/or Alcohol related information

\_\_\_\_\_ Medication List/Log    \_\_\_\_\_ HIV-related information    \_\_\_\_\_ Letter

\_\_\_\_\_ Medical related information    \_\_\_\_\_ Legal information    \_\_\_\_\_ Billing and/or Financial information

\_\_\_\_\_ Insurance information    \_\_\_\_\_ Financial information

\_\_\_\_\_ Other (describe information in detail): \_\_\_\_\_

The reason I am authorizing release is (*please initial each that applies*):

\_\_\_\_\_ My request    \_\_\_\_\_ Coordination of Care    \_\_\_\_\_ Assessment    \_\_\_\_\_ Treatment Planning

\_\_\_\_\_ Other (describe): \_\_\_\_\_

I fully understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. I fully understand that the protected health information may be in written, oral, or report form.

I fully understand that by signing this form I hereby waive or give up my rights of confidentiality to those above named and their supervisors. Unauthorized redisclosure by recipient of this information is a potential risk.

Except as to third party payers, this authorization does not include disclosure for future health care services received more than ninety (90) days from the date of last signature. This release/waiver may be revoked in writing at any time, except to the extent that disclosure has already been made in good faith reliance on this release.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

Signed: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Signed: \_\_\_\_\_

(Parent / Guardian)

**PLEASE TURN OVER AND READ BACK SIDE**

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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.

\_\_\_\_\_ **INITIAL** here that you have read the above information.