THE RIVERWALK GROUP LLC
The Phillips Mansion
666 Glenbrook Road, 1st Floor
Stamford, CT 06906
T: 203.329.3759
www.TheRiverwalkGroup.com

Authorization for Use or Disclosure of Protected Health Information (PHI)

Name of Patient: ____

USE AND DISCLOSURE OF PSYCHOTHERAPY NOTES

I hereby authorize ____
Name of Riverwalk Group Clinician or "The Riverwalk Group"

to release **Psychotherapy Notes** concerning me to the following recipient:

Person/Organization: ____

Address: ____

____

The following information is to be released: Psychotherapy Notes – Authorization for *Psychotherapy Notes ONLY*

Date(s) of service:____

or range of service dates: from: ____________________ to _________________________ (inclusive)

PURPOSE: The purpose for the release of this information is:

- ☐ Continuity of care (transfer to another therapist or health care provider) *
- ☐ Insurance or other third party reimbursement
- ☐ Pending legal action (attorney)
- ☐ At the request of the patient
- ☐ Other: (Specify):____

*If, for continuity of care, records needed for appointment on (date)_____________ at (time) _________ .

RESTRICTIONS:

I understand that if the person or entity that receives the information is not a health care provider or a health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I realize that the office and its employees have a responsibility to maintain the confidentiality of the medical records in its possession. I understand that once the information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

The office will not be held responsible for any subsequent disclosure by the recipient of the health information. I release The Riverwalk Group and employees of any liability that may arise because of any subsequent disclosure of my pursuant to this authorization could be re-disclosed by the recipient.

____
Signature of Patient   Date

____
Signature of Personal Representative   Date

This Authorization will expire on: _____/_____/______ or upon the happening of the following event: _____________

____

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Authorization for use or disclosure of protected health information

This form is used to authorize the release of psychotherapy notes in accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

HIPAA provides special protections to certain medical records known as "psychotherapy notes." 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 separated from the rest of the individual's medical record."

Excluded from the definition are the following:

- Medication prescription and monitoring
- Counseling session start and stop times
- The modalities and frequencies of treatment furnished
- Any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date

In order for a medical provider to release psychotherapy notes to a medical provider, an attorney or other third party, the patient who is the subject of the psychotherapy notes must sign a HIPAA-compliant authorization form that specifically allows for the release of the psychotherapy notes. Such authorization must be separate from an authorization to release other medical records; therefore, two authorization forms must be signed by the patient for the provider to release medical records and psychotherapy notes.

Completion of this document authorizes the disclosure and/or use of psychotherapy notes. Failure to provide *all* information requested may invalidate this authorization.