



Name: _____

MRN: _____

PATIENT AUTHORIZATION FOR DISCLOSURE

PSYCHOTHERAPY NOTES

INSTRUCTIONS

Fill in the appropriate information in each applicable section. Sign and date the form. Incomplete forms will be returned to you unprocessed. A separate authorization must be completed for each request.

Patient Full Name: _____ Maiden Name: _____
Last First Initial

Date of Birth: _____ SS# _____ Sex: M / F Telephone: () _____

I, _____ hereby authorize _____
 it's director or agent, to disclose information contained in the medical record of the patient identified above, which includes information that may be stored in a paper and/or electronic format. Notes may contain information on general medical care; alcohol and drug abuse treatment; psychological and social work counseling; human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) or AIDS related complex (ARC); communicable diseases or infections, including sexually transmitted diseases, venereal diseases, tuberculosis and hepatitis; demographic information; and treatment received at other health care providers.

This authorization is for the disclosure of psychotherapy notes only.

1. Name or title of person or organization and **address** to whom information is to be:

Disclosed To:

Requested From:

2. The purpose or need for such disclosure

___ At the request of the patient ___ Personal Use ___ Continuation of Care ___ Attorney

___ Workman's Compensation ___ Insurance ___ Disability Other: _____

3. The psychotherapy notes to be disclosed are for the **dates of service** indicated below.

 _____ psychiatric consultation

4. This authorization is valid only if received by Henry Ford Health System within 60 days of the date signed. This authorization expires when the patient information is disclosed as permitted in this authorization, or on _____ (date cannot exceed one year from the date of signature below).

5. I may revoke this authorization at any time. Revocations to this authorization must be presented in writing. Revocation will not apply to the information that has already been released pursuant to this authorization.

6. My care or treatment will not be conditioned on signing this authorization.

7. The persons to whom information is disclosed under this authorization may possibly re-disclose the information to others without the patient's knowledge or consent and therefore the privacy of personal and health information may no longer be protected by law.

8. Henry Ford Health System and/or its copying services reserve the right to charge for processing and copying information. The fee is waived when releasing information **directly** to a treating physician or health care facility.

Signature: _____
 Patient, Parent or Minor, Legal Guardian, Personal Representative*

Relationship (if other than patient): _____

Date: _____

*If Legal Guardian, Personal Representative, or person with authority
 under a durable power of attorney, a copy of appropriate documentation is necessary for release.