

Authorization for Use or Disclosure of Psychotherapy Notes

Use this form to authorize the release of Psychotherapy Notes in accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). See 45 CFR 164.508(b)(3)(ii)

AUTHORIZATION TO DISCLOSE PSYCHOTHERAPY NOTES OF:															
NAME LAST	FIRST	MIDDLE	DATE OF BIRTH												
The following information may help in locating records:		FORMER NAMES													
CLIENT IDENTIFICATION NO.	OTHER IDENTIFICATION NO.	DATES OF SERVICE	LOCATION OF SERVICE												
DISCLOSE TO:															
NAME LAST	FIRST	MIDDLE	TITLE												
ORGANIZATION OR BUSINESS NAME IF APPLICABLE															
ADDRESS		CITY	STATE ZIP CODE												
TELEPHONE NUMBER (AND AREA CODE)	FAX NUMBER (AND AREA CODE)	E-MAIL ADDRESS													
REASON FOR DISCLOSURE (NOT REQUIRED)															
AUTHORIZATION:															
<p>SOURCES: I authorize the following DSHS programs to disclose or give access to Psychotherapy Notes about me as described below. Information may be provided verbally or by computer data transfer, mail, fax, or hand delivery.</p> <p><input type="checkbox"/> The following programs only (check all that apply):</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Office of Forensic Mental Health Services (OFMHS)</td> <td><input type="checkbox"/> Community Services (CSD – public assistance)</td> </tr> <tr> <td><input type="checkbox"/> Child Support (DCS)</td> <td><input type="checkbox"/> Home and Community Services (HCS)</td> </tr> <tr> <td><input type="checkbox"/> Developmental Disabilities (DDA)</td> <td><input type="checkbox"/> Residential Care Services (RCS)</td> </tr> <tr> <td><input type="checkbox"/> Special Commitment Center (SCC)</td> <td><input type="checkbox"/> State Mental Health Institutions (ESH, WSH, CSTC)</td> </tr> <tr> <td><input type="checkbox"/> Vocational Rehabilitation (DVR)</td> <td><input type="checkbox"/> Human Resources Division</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> Other: _____</td> </tr> </table> <p><input type="checkbox"/> All parts of the Department of Social and Health Services (DSHS)</p>				<input type="checkbox"/> Office of Forensic Mental Health Services (OFMHS)	<input type="checkbox"/> Community Services (CSD – public assistance)	<input type="checkbox"/> Child Support (DCS)	<input type="checkbox"/> Home and Community Services (HCS)	<input type="checkbox"/> Developmental Disabilities (DDA)	<input type="checkbox"/> Residential Care Services (RCS)	<input type="checkbox"/> Special Commitment Center (SCC)	<input type="checkbox"/> State Mental Health Institutions (ESH, WSH, CSTC)	<input type="checkbox"/> Vocational Rehabilitation (DVR)	<input type="checkbox"/> Human Resources Division	<input type="checkbox"/> Other: _____	
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<input type="checkbox"/> Other: _____															
<p>RECORDS: I authorize the following DSHS records of Psychotherapy Notes to be disclosed:</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Psychotherapy Notes held by parts of DSHS marked above</td> <td><input type="checkbox"/> All my client records related to Psychotherapy Notes</td> </tr> <tr> <td><input type="checkbox"/> Psychotherapy Notes held by programs on the attached list</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Psychotherapy Notes in employment-related records</td> <td></td> </tr> </table> <p>I want to limit the Psychotherapy Notes to be disclosed as follows (by date, type of record, etc.):</p>				<input type="checkbox"/> Psychotherapy Notes held by parts of DSHS marked above	<input type="checkbox"/> All my client records related to Psychotherapy Notes	<input type="checkbox"/> Psychotherapy Notes held by programs on the attached list		<input type="checkbox"/> Psychotherapy Notes in employment-related records							
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<p>PLEASE NOTE: If your client or other confidential records include any of the following information, you must complete a separate authorization form.</p> <p>SPECIAL RECORDS: HIV/AIDS and STD test results, diagnosis or treatment records (RCW 70.02.220); Mental health records (RCW 70.02.230 or 240); and/or Substance Use Disorder records (42 CFR Part 2)</p>															
<ul style="list-style-type: none"> This permission is valid for 180 days or <input type="checkbox"/> until _____ (date or event, if not checked, will be 180 days). I may revoke or withdraw my permission in writing at any time, but that will not affect information already produced. I understand that my records may no longer be protected under the laws that apply to DSHS after this they are produced. A copy of this form is valid to give my permission to disclose Psychotherapy Notes. <p>DSHS may charge to provide copies of its records.</p>															
AUTHORIZED BY (SIGNATURE)		DATE SIGNED	TELEPHONE NUMBER (AND AREA CODE)												
PRINT NAME		WITNESS/NOTARY (SIGN AND PRINT NAME, IF APPLICABLE)													
<p>If I am not the person who is the subject of the records, I am authorized to sign because I am the: (attach proof of authority)</p> <p><input type="checkbox"/> Parent of minor <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Personal Representative <input type="checkbox"/> Other:</p>															

Notice to those receiving information: You may not further disclose Psychotherapy Notes under federal and state law without specific permission of the subject and meeting specific legal requirements.

INSTRUCTIONS FOR COMPLETION OF PSYCHOTHERAPY NOTES AUTHORIZATION FORM

Purpose: You should use this form when you want DSHS to be able to disclose Psychotherapy Notes about you to another person (including an attorney, a legislator, or a relative). You may give permission to disclose all Psychotherapy Notes DSHS has about you or you may limit your permission to specific records or parts of the agency. This form will also permit DSHS to discuss your situation verbally with the person you authorize.

Notice to Clients: Most client information DSHS has is confidential and will not be disclosed to others unless you grant permission or if disclosure is allowed by law. After DSHS discloses your Psychotherapy Notes, please be aware that the recipient may not protect your records under the same laws that apply to DSHS. DSHS cannot refuse you benefits if you do not sign this form to allow disclosures to DSHS unless your authorization is needed to determine eligibility. For information on how DSHS health care components covered by HIPAA share protected health information and your privacy rights, please consult the DSHS Notice of Privacy Practices at www.dshs.wa.gov or ask the person who gave you this form. You may get a copy of this form.

Use: You may fill out this form electronically or by hand. Use the tab key on a computer to move between fields. **A separate form must be completed for each person whose records are requested, including children.** "You" refers to the subject of the records.

Parts of Form:

IDENTIFICATION OF SUBJECT OF RECORDS:

- **Name:** Provide your full name or the name of the person whose records are requested if you are acting for someone else.
- **Date of birth:** Please include this information needed to identify you from persons with similar names.

OPTIONAL INFORMATION to help locate records:

- **Former names:** Include any other names that have been used when receiving benefits or services.
- **Client identification number:** Provide any number that DSHS may have assigned.
- **Other identification number:** Include any other identifier that could help locate DSHS records. Only provide a social security number if necessary.
- **Date and location of services:** Provide this information to help DSHS identify and locate the records you want disclosed.

PERSON RECEIVING RECORDS:

- **Identification:** Please fill out this section as fully as possible so we can contact the person or organization who will have access to your Psychotherapy Notes.
- **Reason for Disclosure:** If you do not fill in this field, DSHS will note the reason for disclosure as being at your request.

AUTHORIZATION:

- **Parts of DSHS:** Please mark either the parts of DSHS you want to disclose records or mark the bottom box in this section if you want to give access to any records DSHS has about you. Write in the name of program in "Other" if not in the list.
- **Information disclosed:** Indicate what records that you want disclosed. You may allow disclosure of all or part of your DSHS client or other confidential records. You may also limit disclosure to client records held only by the parts of the agency marked in the section above, or to specific records listed on this form or on an attachment you sign. If there are any limitations on what records you want disclosed, either list specific records or describe the limits, such as by date of services or type of record.
- **Restricted records:** If any of the records may include information about HIV/AIDS or STD testing or treatment, mental health treatment other than Psychotherapy Notes, or drug and alcohol services, you must complete a separate authorization form to allow DSHS to disclose these records.
- **Validity:** This form is valid to give access to Psychotherapy Notes currently held by DSHS. Your permission expires 180 days after signature or on any other date or event you provide. If you do not provide a date, the authorization will be valid for 180 days. You may revoke the authority to release records in writing at any time but your revocation will not affect information already produced.
- **Cost:** The public records act in RCW 42.56.120 and WAC 388-01-080 allow DSHS to charge for copies of records plus mailing costs. State hospitals and health care facilities may charge for patient records under Chapter 70.02 RCW.

SIGNATURES:

- **If you are the subject of the records,** sign and also print or type your name below. Insert the date you signed plus your telephone or contact number.
- **If you are signing for another person,** indicate why you can do so on the last line and attach a copy of the court order or other document giving you legal authority. Children must also sign to give permission to disclose their own confidential records if they are over the age of consent (13 for mental health services).
- **Witness or notary:** A witness or notary may be needed to verify your identity if you do not submit this form in person or if a program requests verification. This person should sign and print his or her name.

Definition of Psychotherapy Notes: The HIPAA Privacy Rule defines Psychotherapy Notes as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the patient's medical record. Psychotherapy Notes do not include any information about medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, or results of clinical tests; nor do they include summaries of diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date. Psychotherapy notes also do not include any information that is maintained in a patient's medical record. See 45 CFR 164.501.