



*Authorization Form for use and disclosure
of Psychotherapy Notes*



Please complete all sections of this form.

**Section A: Information About the Individual Providing
Authorization to Release Information**

Name: _____ Date of Birth: ____/____/____

Address: _____

City: _____ State: _____ Zip: _____

Day time phone: _____ Social Security Number: _____ - _____ - _____

Section B: Person/Company Allowed to Release the Information

Name: _____

Address: _____

Company/Agency/Facility Name (if applicable): _____

Section C: Person/Company/Agency or Facility Allowed to Receive the Information

Name: _____

Address: _____

Company/Agency/Facility Name (if applicable): _____

Section D: The Information Being Released

By completing this form, you authorize the use and disclosure of your psychotherapy notes to the person or entity named in Section C. Due to the highly sensitive nature of psychotherapy notes, federal law requires this special individual authorization. Psychotherapy notes include, but are not necessarily limited to, notes taken by your psychotherapist in the course of or relating to your diagnosis or treatment. If you wish to release other protected health information, please complete the Individual Authorization Form.

Date(s) of the information (if applicable): ____/____/____ to ____/____/____ or _____

**AUTHORIZATION FORM FOR USE AND
DISCLOSURE OF PSYCHOTHERAPY NOTES (cont.)**

Section E: Reason for the Release of Information (check only one)

At the request of the individual named in Section A; or

Other: Please state the other purpose for release of the information:

Section F: Expiration Date

If not previously revoked, this authorization will terminate on the earliest of the following dates:

- One year from the signature date below; or
- Upon the following date, event* or condition*:

For authorization to terminate due to an event or condition, the party identified in Section B must be notified **in writing upon occurrence of the event or condition.*

Section G: Signature

I understand and agree that the information to be disclosed may also include the following types of information which are protected under Nevada or other federal law: blood, breath or urine tests; communicable disease information, including information about sexually transmitted disease, including HIV and AIDS; information about mental health treatment I sought and/or received; information about drug and/or alcohol abuse treatment I have sought and/or received.

A copy of this authorization is available to me, or to my authorized representative, upon request and will serve as the original. I understand that if this information is disclosed, it may no longer be protected by federal privacy laws.

I have the right to revoke this release of information/authorization at any time, except to the extent that the person/company has already taken action on the disclosure provisions contained in this document. If I choose to revoke the release of information/authorization, I must notify the person/company identified in Section B **in writing** that I request termination of this release of information/authorization.

Signature: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the individual, please complete the following and attach a copy of the representative's authority to this form (e.g., Executor/Administrator of an estate):

Personal Representative's Name: _____

Relationship to Patient: _____