

AUTHORIZATION FOR USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES

I, _____, [Print Name of Individual (i.e., patient, resident or client)] hereby authorize Carrington Health Center to use and/or disclose my psychotherapy notes as described below:

I authorize the following person(s) or organization(s) to receive my psychotherapy notes:

Name: _____
Street Address: _____
City, State, and Zip Code: _____

The following **psychotherapy notes** may be used and/or disclosed:

Date(s) of session(s) to be released: _____

I authorize the release of any information contained in the above records concerning the treatment of:

- Drug or alcohol abuse;
- Drug-related conditions;
- Alcoholism;
- Psychiatric/psychological condition;
- Psychiatric/mental health treatment; and/or
- HIV-related conditions

Reason or purpose for the use and/or disclosure of the information:

Prohibition on Conditioning of Authorization: Carrington Health Center will not condition treatment on your signing this authorization, unless:

- You are receiving research-related treatment; or
- The only reason the facility is providing you with health care is to make a report to a third party, such as your employer (e.g., fitness to return to work) or school (e.g., P.E. physical).

Re-disclosure: I understand that the information used and/or disclosed according to this authorization may no longer be protected by federal privacy law (also known as HIPAA) and the recipient of your health information may potentially disclose it. However, under the Federal Substance Abuse Confidentiality Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

Expiration: This authorization will expire _____ (insert date or event or insert "once purpose stated above is served").

Revocation: I understand that I may revoke this authorization at any time by notifying Carrington Health Center in writing by sending a letter to **PO Box 461, Carrington, ND 58421 Attn: Medical Records** or completing the Revocation of Authorization form. I understand that if I revoke this authorization, it will not affect any actions that Carrington Health Center took, made, and may use my health information as necessary to bill and collect for services rendered.

This Authorization is binding: The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in the Carrington Health Center's Notice of Privacy Practices.

SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE

DATE

Printed name of individual's personal representative, if applicable: _____
Rationale for serving as personal representative to the individual (e.g., parent, legal guardian): _____

FOR INTERNAL PURPOSES ONLY

When Carrington Health Center is requesting an authorization to use health information for its own use, the following provision must be completed:

Staff Personnel:

Received by: _____ Date: _____

Was a signed copy provided to the individual? YES NO