MR#_____

MARTIN HEALTH SYSTEM

AUTHORIZATION FOR RELEASE OF PSYCHOTHERAPY NOTES

Full Name: _____

Date of Birth: _____ Social Security Number: _____

Dates of Service: From _____ Through _____ or Account Number _____

I, _____, hereby request and authorize Martin Health System to release my **Psychotherapy Notes and/or** information from my **Psychotherapy Notes** to the recipient named below:

To:

_____

Full Name and Mailing Address for Recipient of Your Records

_____

City State Zip Code

_____

Telephone Number Fax Number E-Mail Address

Reason for Disclosure: (Must be completed prior to processing)

_____

Psychotherapy Notes are defined as notes that document private, joint, group or family counseling sessions that are separated from the rest of a patient's medical record. If you are requesting the records for yourself, the physician may provide a report of examination and treatment instead of copies of the records.

Pursuant to Florida law and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule, the record may be given only to the person designated, and it may be used only for the purpose listed on this form. Charges are in compliance with Florida law. I understand that once my information is disclosed to the recipient above, it may be redisclosed to individuals not subject to HIPAA and may no longer be protected by HIPAA. A covered entity (that is, a source of medical information about you) may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization form. I understand that I may revoke this authorization at any time, in writing, to the address listed below, Att: Health Information Management Department provided that the information has not yet been released. This authorization expires in six (6) months from the date this authorization was signed below, unless another date is written here _____. Martin Health System is hereby released from any responsibility for maintaining the confidentiality of information released to me or parties designated by me in this authorization, such release being made in good faith.

_____/_____/ ___/___/____

PATIENT OR AUTHORIZIED SIGNATURE PRINTED NAME DATE

Relationship to Patient: _____

Explain and/or attach Legal Documentation

APPROVED BY (Physician approval required only when releasing records to the patient)**:**

_____/_____/ ___/___/____

PHYSICIAN'S SIGNATURE PRINTED NAME DATE