AUTHORIZATION FOR RELEASE OF PSYCHOTHERAPY NOTES

Name: _____ DOB: _____ SS# _____
(Please print)

I give permission for Integral Care to release and or share my psychotherapy notes with:

Name of Agency / Person: _____
Address: _____
_____
Phone Number: _____
E-Mail Address _____

INFORMATION TO BE RELEASED: Psychotherapy Notes Only
I understand that this authorization extends to psychotherapy notes contained in my records. The notes may include information about mental illness, intellectual/developmental disabilities, substance use disorders, communicable diseases such as HIV/AIDS, and genetic information, unless one or more of the following boxes are checked:

Do not release information regarding: ☐ Substance Use Disorders ☐ Genetic Information ☐ Communicable Diseases (including HIV/AIDS)

PSYCHOTHERAPY NOTES TO BE RELEASED SHOULD COVER THE TIME PERIOD FROM _____TO_____
If no time period is given, the information released will cover all information prior to the expiration date of this authorization form.

THE PURPOSE OF THE RELEASE IS FOR THE FOLLOWING:
☐ Continuity of Care ☐ Disability Benefits ☐ At my request ☐ Other: _____
☐ Legal ☐ School ☐ Insurance

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I understand that I can see the protected health information that will be disclosed. If this information is for myself, I can request that it be given to me electronically. I understand that my protected health information may be released electronically. This authorization extends to information released in electronic, paper, and verbal format.

This authorization can be cancelled at any time, in writing, to Integral Care, but the cancellation will not affect any disclosures already made prior to receipt of cancellation notice. The PHI disclosed may be subject to re-disclosure by the recipient and may no longer be protected by state and federal privacy protections. Integral Care cannot control how the protected health information will be used by the agency/person who receives it under this authorization.

Unless cancelled or otherwise specified, this authorization will expire one year from date of signature.
Other specified expiration date: _____

Client Signature: _____ Date: _____

Parent / Legal Guardian Signature: _____ Date: _____

Printed Name: _____ Relationship: _____

DISCLOSURE STATEMENT: This information may be disclosed to you from records protected by Federal confidentiality rule 42 CFR part 2. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Please submit request for medical records to:
Integral Care-Medical Records Department
P.O. Box 3548
Austin, Texas 78764-3548
(512) 440-4075
(512) 445-7726 (FAX)
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