

THREE IMPORTANT STEPS

I'm pleased to serve you by transferring your chart to another service provider. Often a chart can be up to 80 pages, so here's how you can help me expedite your request:

1. Include the fax number of the doctor or agency that will receive your medical records. Without this, we will be unable to fulfill your request.
2. Your psychotherapy notes were taken in the context of marital or family therapy (unless you came by yourself). Therefore, each person over 18 must sign the release if you want to have your psychotherapy notes released to a third party. Otherwise, the only portions that I can release are those unique to you – your psychological test and your intake.
3. Please allow up to three full working days for us to release your records.

AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH INFORMATION

I hereby authorize release of my confidential health information as described below. I understand this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

Client name: _____

Provider or Facility providing the information:

Persons/organizations receiving the information:
(include mailing address, phone, and fax number -
otherwise, we will be unable to facilitate your request)

Description of specific information to be disclosed (including dates of service):

Does this include authorization to release drug or alcohol abuse treatment records? Yes ____ No ____ (please initial)
Does this include authorization to release psychotherapy notes? Yes ____ No ____ (please initial)

The release of information is being made:
 At the request of the individual
 At the request of another, explain the purpose of the request. _____

This authorization will expire on ____/____/____ (DD/MM/YY)

Carefully read the following statements before signing this authorization:

- 1. I may revoke this authorization at any time in writing, except as to information released before receipt of the revocation.
- 2. I understand that my health care will not be denied if I refuse to sign this authorization.
- 3. Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer subject to privacy protections.
- 4. I am entitled to a copy of this authorization.

Signature of Client or Client's representative

Date

Printed name of Client's representative:

What is the representative's authority to act on behalf of the Client?

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION