



Z26188 Authorization for Release of Psychotherapy Notes

Patient Information: I give permission to release the Psychotherapy Notes of: (One patient per form)

Patient Name: _____ Date of Birth: _____
Street Address: _____ MR# or last 4 of SSN _____
City, State, Zip: _____ Telephone: () _____
Email address: _____

Release Information From: _____
(List applicable Facility(s) and/or Practice(s)
_____)
(Phone number) _____
Release Information To: _____
(Name of facility, person, company) (Relationship)
_____)
(City, State, Zip Code)
_____)
(Phone number) (Fax number) _____

PURPOSE OF RELEASE (check reason): Request of individual/personal Continued patient care Insurance
 Legal purpose including discussions & proceedings Other _____

Fill in the dates of therapy sessions for Psychotherapy Notes to be released:
Dates of therapy sessions: From: _____ To _____

FORMAT: (Check all that may apply)
 CD (charges may apply)
 Paper copy (charges may apply)
 Other _____
DELIVERY METHOD:
 Reg. US Mail Pick-up Fax, where permitted
 Secure email, where permitted
 Other _____

PATIENT'S RIGHTS - I understand that:
I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to releasing facility or practice named above. Any cancellation will apply only to information not yet released by the facility or practice.
This is a full release which may include information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetics, HIV/AIDS, and other sexually transmitted diseases.
Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.
Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in health plan, or eligibility for benefits.
Navicent Health will not share or use my health information without my permission other than by ways listed in Navicent Health's Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is available at Navicenthealth.org
A fee may be charged for providing the protected health information. I have a right to receive a copy of this form upon request.

This permission expires 90 days after the date of my signature unless an earlier date or event is written here: _____
Signature: _____ Print Name: _____ Date: _____ Time: _____

Note: if the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form. Note the relationship/authority if signature is not that of the patient: (Written Proof May be Requested)

Healthcare Agent/POA Guardian Executor/Administrator/Attorney in Fact Spouse
 Parent Adult Child Affidavit of Kin Other _____

Note: If minor consented for their outpatient treatment for pregnancy, sexually transmitted disease or behavioral/mental health without parental consent, the minor must sign this authorization. When the patient is a minor being treated for substance abuse, the minor must sign this authorization, regardless of who consented for treatment.

Signature: _____ Print Name: _____ Date: _____ Time: _____

