Place Patient Label Here **or**

Print Patient Name

Account Number

UAMS
UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

Authorization for Release of Psychotherapy Notes

(*If other types of documents are to be released, use HIPAA compliant authorization form.* ***Do not*** *use this authorization form to release documents other than psychotherapy notes.*)

1. I, _____, hereby authorize UAMS to release to:

   Name_____ Phone:_____

   Address:_____

2. Information of:

   Patient Name_____ Medical Record No. (if known)_____

   Date of Birth and/or Social Security No._____ Phone: _____

3. Information is to be limited to the following **Dates of Treatment** (if applicable):_____

4. Information requested to be released:

   _____ Psychotherapy Notes Only.

I understand that **if** the records requested to be released include information relating to **sexually transmitted disease, AIDS or HIV, alcohol or drug use, or mental health information**, this information may be released pursuant to this authorization.

5. Purpose of access or release: _____ Medical Care _____ Insurance or Other Payment _____ At Request of the Patient _____ Other (explain): _____

6. **This authorization will expire on the following date:** _____. If no date is specified, this authorization shall expire one (1) year from the date signed below. I understand that I may revoke this authorization at any time by giving written notice to UAMS, except that a revocation of this authorization will not apply to records already released in reliance upon the authorization. A photocopy of this signed authorization shall constitute a valid authorization.

7. UAMS, its employees and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

8. I understand that once the above information is disclosed, it may be re-disclosed by the designated recipient and the information may no longer be protected by Federal privacy laws and regulations.

9. I agree to pay the copying cost, including other expenses allowed by law, such as the cost of any supplies, labor of copying, postage, or other expenses incurred by UAMS to provide the copies requested.

10. UAMS will not condition treatment, payment, enrollment or eligibility for benefits on your signing of this authorization.

Signature of Patient or Legal Representative _____ Date: _____

If Legal Representative, authority of Legal Representative _____
(such as parent of a minor, court-appointed guardian, administrator of estate of deceased, attorney-in-fact appointed with power of attorney for healthcare-related decisions, or a healthcare proxy)

_____

Approved by Originator of Psychotherapy Note or other UAMS Mental Health professional:

Print Name _____ Signature: _____

HIPAA **PROVIDE COPY TO PATIENT/LEGAL REPRESENTATIVE**