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 numbers of _____

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
☐ Overnight/Express Mail Service, 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.**
- **CHS will not share or use my health information without my permission other than by ways listed in CHS's Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is available at carolinashealthcare.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 one year after the date of my signature unless an earlier date or event is written here: _____

Signature: _____**Print Name:** _____**Date:**_____

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 Next 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 of Minor:_____**Print Name:** _____**Date:** _____

Authorization given to patient / Date of release:_____via ☐Mail ☐Fax ☐Other_____☐ ID Verified ☐ DL/Other ID_____
CHS Employee Name & Title: _____**CHS Employee Signature:** _____**Date**_____

Patient Information or Sticker

Name:

DOB:

Medical Record #:

* 9 0 5 *

Carolinas HealthCare System

AUTHORIZATION FOR RELEASE OF PSYCHOTHERAPY NOTES