Padma Desai Counseling and Consulting, LLC
Psychotherapy and Counseling for Adults
(973) 214-8094
www.padmadesai.com
padma@padmadesai.com

Authorization for Release of Protected Health Information (PHI)

Patient Name: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

Home Address: _____

_____

Date of Birth: _____

DATES OF SERVICE REQUESTED: _____

DESCRIPTION OF INFORMATION TO BE RELEASED (Please Check All That Apply):

- ☐ Documentation Relating to Outpatient Treatment
- ☐ Discharge Summary
- ☐ Verbal Communication Relating to Outpatient Treatment
- ☐ Other

Specific Confidential Information Authorized for this Release: I understand that my records may contain any of the following if applicable: HIV/AIDS, Sexually Transmitted Disease, Mental Health and/or Psychiatric Information, Drug and Alcohol Usage and Treatment, and Genetic Information. Please indicate if you do NOT want this information released by signing and dating here and please specify which information is NOT to be released: ___

_____

PURPOSE OF RELEASE: I hereby authorize Padma Desai Counseling and Consulting, LLC to disclose/release my PHI for the following specific purpose (Please Check All That Apply):

- ☐ Coordination of Care
- ☐ Emergency Contact
- ☐ Self
- ☐ Other (Please specify)_____

RELEASE INFORMATION TO:

Name: _____ Relationship/Organization: _____

Street Address: _____Phone:_____

Fax: _____City: _____ State: _____ Zip Code:_____

Padma Desai Counseling and Consulting, LLC
Psychotherapy and Counseling for Adults
(973) 214-8094
www.padmadesai.com
padma@padmadesai.com

Authorization for Release of Protected Health Information (PHI)

TERM OR EXPIRATION: This signed authorization will expire upon the occurrence of

(specify):_____

SIGNATURE OF AUTHORIZATION: I hereby authorize Padma Desai Counseling and Consulting, LLC to disclose/release my health information listed above for the purpose and have reviewed this Authorization and the attached patient rights and HIPAA authorization. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential PHI. I understand that I have the right to receive a copy and this authorization if I so request. (A copy is valid as the original).

Patient (Print):_____ Date: _____ Time: _____

Patient (Signature): _____Date: _____ Time: _____

Name of Authority (Print if applicable): _____Date: _____ Time: _____

Name of Authority (Signature if applicable): _____ Date: _____ Time: _____

Relationship of Authority: (Please check all that apply):
□ Next of Kin
□ Parent
□ Power of Attorney
□ Other (Specify)

Clinician: Padma Desai, LPC, NCC (Print): _____

Clinician: Padma Desai, LPC, NCC
(Signature):_____

Date: _____Time:_____

Padma Desai Counseling and Consulting, LLC
Psychotherapy and Counseling for Adults
(973) 214-8094
www.padmadesai.com
padma@padmadesai.com

Authorization for Release of Protected Health Information (PHI)

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").

1. Tell your mental health professional if you don't understand this authorization, and they will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to your mental health professional and your insurance company, if applicable.

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment, or affect your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program, or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, Padma Desai Counseling and Consulting, LLC has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by federal HIPAA regulations.

5. If this office initiated this authorization, you must receive a copy of the signed Authorization for Release of Protected Health Information (PHI).

6. Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes:
Federal HIPAA regulations provide special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the patient's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. In order for a medical provider to release "Psychotherapy Notes" to a third party, the patient who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical records.