

HIPAA AUTHORIZATION FOR PSYCHOTHERAPY NOTES

Check the name of the person/organization disclosing the information:		
<input type="checkbox"/> University Hospital of Brooklyn – Main Campus	<input type="checkbox"/> SUNY Downstate Medical Center at Bay Ridge	<input type="checkbox"/> Student/Employee Health
<input type="checkbox"/> University Hospital of Brooklyn – Lefferts	<input type="checkbox"/> University Hospital of Brooklyn – Dialysis Center	<input type="checkbox"/> Other; Specify _____
<input type="checkbox"/> University Hospital of Brooklyn – Midwood	<input type="checkbox"/> Research Foundation (RF)	
Patient Last Name, First Name:	Maiden or Other Name:	Patient Date of Birth:
Patient Address:		
City, State & Zip:	Telephone: (Area Code and Number)	Medical Record Number:
Name, address and telephone number of person or entity to whom this information will be sent:		
Specific psychotherapy notes to be disclosed: -----		
This information is being used or disclosed for the following purposes:	<input type="checkbox"/> Treatment <input type="checkbox"/> Legal <input type="checkbox"/> Other: _____	
<ul style="list-style-type: none"> • By signing this authorization form, you authorize the use or disclosure of your protected health information as described above. This information may be re-disclosed if the recipient(s) described on this form is not required by law to protect the privacy of the information. • You have a right to refuse to sign this authorization. Your healthcare, the payment for your healthcare and your healthcare benefits will not be affected if you do not sign the form. • You have a right to receive a copy of this form after you sign it. • You have the right to revoke this authorization at any time, except to the extent that action has already been taken based upon your authorization. To revoke this authorization, please write to: SUNY Downstate Medical Center, Department of Health Information Management Correspondence Unit – Box #119, 450 Clarkson Avenue, Brooklyn, NY 11203 		
I understand that this authorization will expire in 6 months from the date this form is signed, unless otherwise stated below: Expiration Date/Event: _____		
By signing below, I certify that I am requesting disclosure of my health information in the manner described above.		
_____ Print Name of Patient/Personal Representative		_____ Signature of Patient/Personal Representative
_____ Description of Personal Representative's Authority		_____ Date

THE PATIENT OR HIS/ HER PERSONAL REPRESENTATIVE SHOULD BE PROVIDED WITH A COPY OF THIS FORM AFTER IT HAS BEEN SIGNED.