SUNY Downstate Medical Center

HIPAA AUTHORIZATION FOR PSYCHOTHERAPY NOTES

Check the name of the person/organization disclosing the information:

☐ University Hospital of Brooklyn – Main Campus	☐ SUNY Downstate Medical Center at Bay Ridge	☐ Student/Employee Health
☐ University Hospital of Brooklyn – Lefferts	☐ University Hospital of Brooklyn – Dialysis Center	☐ Other; Specify _____
☐ University Hospital of Brooklyn – Midwood	☐ 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:

- ☐ Treatment
- ☐ Legal
- ☐ Other: _____

- 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.