Alliance For HEALING

Authorization to Release & Disclose Patient Information

PATIENT INFORMATION	Patient's Name: _____ Date of Birth: _____ Address: _____ Phone: _____ City: _____ State: _____ Zip: _____
I AUTHORIZE	**Alliance for Healing PA** 4505 White Bear Parkway, STE 1500, White Bear Lake, MN 55110 PHONE (651) 493-8150 | FAX (651) 493-9335
PROVIDER *(Who is your provider at Alliance for Healing?)*	☐ **Dr. Diane Hovey, PhD, LMFT, CSAT** ☐ **Iris Heieren, MA, LAMFT** ☐ **Catherine Gerth, MA, LMFT** ☐ **Carol Ladd, MSW, LICSW, LSSW** ☐ **Eve Kaldahl, MA, LPCC, LADC** ☐ **Andrea Walker, MA, LPCC Candidate** ☐ **Mary McNamara, MA, LPCC** ☐ **Tara Burk, LMFT** ☐ **Charlie Bulman, MPS, LADC, LPCC** ☐ **Shannon Himango, MA, LMFT** ☐ **Lydia Garcia, MSW, LGSW** ☐ **Sarah Dietsche, LAMFT**
TO DO THE FOLLOWING ☐ Release to ☐ Receive from ☐ Both	Agency/Clinic Name: _____ Provider name: _____ Email: _____ Street address: _____ City: _____ State: _____ Zip: _____ Phone number: _____ Fax number: _____
INFORMATION TO BE RELEASED *(What do you want sent or released?)* *Check the appropriate box(s)*	☐ **Any and all clinical records** ☐ **All records dated from _____ to _____** ☐ **Psychological Testing and Interpretive Report** ☐ **Verbal** (To speak with or to the other clinician) ☐ **Verbal only.** Do not release any records. ☐ Other (describe in detail) _____ All records pertaining to alcohol, drug abuse, and AIDS related illness will not be released unless indicated: ☐ **Yes, release** ☐ **No, do not release**
PURPOSE OF RELEASE *(Why is it needed?)* *Check the appropriate box(s)*	☐ Continuing Care ☐ Social Security Appeal* ☐ Social Security Disability* ☐ Insurance Payment/Claim ☐ Litigation/Legal* ☐ Personal Use or Review* ☐ Other*: _____ *Fees may be charged in accordance with MN State Statue 144.292 and Federal Rule 45 C.F.R. 164.524

Authorization and Signature: I authorize the release of my confidential protected health information, as described in my directions above. 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 re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information. I understand that I can request, in writing, that the authorization be cancelled at any time. ***THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.***

Patient Name (printed) _____

Patient Signature _____ Date _____

Parent Signature & Relationship to Patient _____
(if patient is unable to sign or under the age of 12. If 12-17 years old, we require the signature of the minor patient, and the parent/guardian both in most cases.)

Alliance For HEALING

Authorization to Release & Disclose Patient Information

You may reach our business office by calling 651-493-8150 or emailing admin@aheartt.com

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").

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

- 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.

- 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 client in their practice.

- Once the information about you leaves this office according to the terms of this authorization, this office 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 HIPAA.

- If this office initiated this authorization, you must receive a copy of the signed authorization.

- ***Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes***. HIPAA provides 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 individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following:

    - Medication prescription and monitoring
    - Counseling session start and stop times
    - The modalities and frequencies of treatment furnished
    - The results of clinical test
    - 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 client 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.