DR. RUTHIE NORMAN LICSW LLC
1029 NORTH RD SUITE 24 7-G WESTFIELD, MA 01085
FAX: 413-315-9684 EMAIL: TTRPS@DRRUTHIENORMAN.COM PHONE: 413-668-2282

Authorization for use or disclosure of protected health information

The following form(s) are used to authorize the release of your medical records/psychotherapy notes in accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

HIPAA provides special protections to certain medical records known as "psychotherapy notes." 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 separated from the rest of the individual's medical record."

In order for a provider to release your medical record/ psychotherapy notes to a medical provider, an attorney or other third party, the client who is the subject of the psychotherapy notes **must sign a HIPAA-compliant authorization form that specifically allows for the release of the psychotherapy notes.**

Such authorization must be **separate** from an authorization to release other medical records; therefore, two authorization forms must be signed by the patient for the provider to release medical records and psychotherapy notes.

Completion of the following document authorizes the disclosure and/or use of psychotherapy notes/medical records. Failure to provide all information requested may invalidate this authorization.

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Fax: 413-315-9684 email: ttrps@drruthienorman.com phone: 413-668-2282

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
(Page 1 of 2)

1. **Client's name**: _____
   First Name Middle Name Last Name

2. **Date of Birth**: _____ 3. **Last 4 of SSN**: _____ 4. **Date authorization initiated**: _____

5. **Authorization initiated by**: _____
   Name

6. **Information to be Used or Disclosed**:

   ☐ My health information relating to the following treatment or condition: _____

   ☐ Most recent ___ years of record

   ☐ My medical records for the following date(s): _____

   ☐ Entire medical record

   ☐ Include ☐ Exclude: My health information related to drug and/or alcohol abuse

   ☐ Include ☐ Exclude: My health information related to HIV/AIDS

   ☐ Psychotherapy Notes [**Note: Must be a separate consent]**

   ☐ Other information to be used or disclose (describe information in detail): _____

   _____

   _____

7. **Purpose of Use or Disclosure**:

   ☐ Continuing Medical Care

   ☐ Insurance/ Disability

   ☐ Disclosure to Employer

   ☐ Personal Use

   ☐ Attorney/Legal Case

   ☐ Other (describe each purpose of the requested use and disclosure in detail): _____

   _____

   _____

8. **Person(s) Authorized to Make the Disclosure**: Dr. Ruthie Norman, LICSW

9. **Person(s) Authorized to Receive the Disclosure**: _____

10. **This Authorization will: ☐ not expire, ☐ expire on** _____ **or ☐ upon the happening of the following event**:

    _____

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.

Signature of the client: _____

Signature of Personal Representative: _____

Relationship to Client if Personal Representative: _____

Date of signature: _____

CLIENT RIGHTS AND HIPAA AUTHORIZATIONS
(Page 2 of 2)

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 provider if you do not understand this authorization, and the provider 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 provider at the following address:

   Dr. Ruthie Norman, LICSW 1029 North Rd Suite 24F-G Westfield, MA 01085

   _____

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you 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, 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 the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.
5. You may inspect or copy the protected health information to be used or disclosed under this authorization. You do not have the right of access to the following protected health information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act ("CLIA") prohibits access, or information held by certain research laboratories. In addition, our provider my deny access if the provider reasonably believes access could cause harm to you or another individual. If access is denied, you may request to have a licensed health care professional for a second opinion at your expense.
6. If this office initiated this authorization, you must receive a copy of the signed authorization.
7. ***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 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: (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. Except for limited circumstances set forth in HIPAA, 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.
8. You have a right to an accounting of the disclosures of your protected health information by provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or health care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individual's health care or payment for health care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to health oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
(Page 1 of 2)

1. **Client's name**: _____
   First Name Middle Name Last Name

2. **Date of Birth**: _____

3. **Date authorization initiated**: _____

4. **Authorization initiated by**: _____
   Name (client, provider or other)

5. **Information to be Released**:

   ☐ Authorization for Psychotherapy Notes ONLY (**Important**: If this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected health information.)

   ☐ Other (describe information in detail): _____

6. **Purpose of Disclosure**: The reason I am authorizing release is:

   ☐ My request

   ☐ Other (describe): _____

7. **Person(s) Authorized to Make the Disclosure**:
   Dr. Ruthie Norman, LICSW 1029 North Road Suite 24F-G Westfield, MA 01085

8. **Person(s) Authorized to Receive the Disclosure**:

9. **This Authorization will expire on _____ or upon the happening of the following event**:
   Upon release of my requested confidential protected health information as described above

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 redisclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

Signature of the client: _____

Signature of Personal Representative: _____

Relationship to client if Personal Representative: _____

Date of signature: _____

PATIENT RIGHTS AND HIPAA AUTHORIZATIONS
(Page 2 of 2)

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 therapist if you don't understand this authorization, and the therapist 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 provider at the following address:
Dr. Ruthie Norman, LICSW 1029 North Rd Suite 24F-G Westfield, MA 01085

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or 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.

4. 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.

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

6. ***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: (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 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.