Health Management Services
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AUTHORIZATION TO RELEASE PSYCHOTHERAPY NOTES

I, _____, _____
(Print name) (DOB)

SPECIFICALLY AUTHORIZE Health Management Services, P.C. to release progress notes, treatment summaries, and results of a psychological assessment from dates: _____ to _____.

The clinical information is to be sent to the following agency:

_____

for the designated purpose of:

_____

I acknowledge Health Management Services, P.C. Clinician has fully informed me that the Health Insurance Portability and Accountability Act (HIPAA) affords special privacy protections regarding "Psychotherapy Notes" in an effort to preserve/protect the confidentiality parameters of the therapeutic relationship. I have also given permission to release progress notes, treatment summaries, and psychological evaluation reports to the above person(s) or agency. I understand HIPAA forbids payors from requiring disclosure of psychotherapy notes as a condition for payment. Psychotherapy notes differ from progress notes. I have discussed this matter with my HMS Clinician and any questions I had are answered.

_____ _____
Patient Signature or Parent of Minor/Legal Charge Date

If legal charge, describe representative relationship:

Representative Relationship: _____

_____ _____
Signature of Office Staff Member (Witness) Date