Authorization for Use or Disclosure of Protected Health Information Psychotherapy Notes Only

Member's Name:	Date of Birth: _____ / _____ / _____
AHCCCS ID:	CIS ID:
Member Address:	

I, or my Authorized Representative, request the release of psychotherapy notes as set forth in this authorization. In accordance with Arizona state law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand the following:

1. **Limited Scope of Authorization**. This authorization includes disclosure of ***psychotherapy notes only*** to the person or entity that I listed below. I understand that a health care provider needs my written authorization to release psychotherapy notes and that this authorization cannot be combined with any other authorization for release of health information (45 CFR § 164.508). If I want to authorize the release of other protected health information, I must sign a separate authorization.
2. **Voluntary Authorization**. Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
3. **Redisclosure**. Information disclosed to a third party under this authorization is prohibited from being redisclosed without your authorization or release. A.R.S. § 12-2294(E).
4. **Revocation**. I have the right revoke this authorization, except to the extent that action has already been taken based on this authorization. I must send any revocation in writing to the person or entity permitted to disclose the information.
5. **Fees**. If I am requesting this information for myself or third party, I may be assessed appropriate and reasonable fees for the copying of such information. Any fees will comply with all state and federal laws.

Name person(s), organization, or program permitted to disclose the information:
_____

Name and address of person(s) or organization(s) to whom this information is to be disclosed:
_____

Purpose of Disclosure: ☐ Member's Request ☐ Other:

Specific Information to be Released (*check appropriate boxes*):

☐ All psychotherapy notes.

☐ Psychotherapy notes from (*insert start date*) _____ to (*insert end date*) _____.

☐ Other (*e.g., psychotherapy notes addressing the topics/issues/concerns identified below*):

_____

_____

Unless revoked, this authorization expires 12 months from date signed unless I specify another Event or Date here:
_____

_____ _____ / _____ / _____

Signature (Member or Authorized Representative*). Date

**If signed by someone other than Member, please specify authority for signing and provide supporting documentation.*