THE DIMOCK CENTER
Healing and caring for the community for over 150 years.

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AUTHORIZATION TO DISCLOSE PSYCHOTHERAPY NOTES

I (the undersigned) hereby authorize, ***The Dimock Center*** to disclose the following identified health information.

PATIENT INFORMATION

Name of Patient: _____ Date: _____

Maiden Name (if applicable): _____ SSN: _____

Date of Birth: _____ E-mail Address: _____

Address: _____ Phone Number: _____

City, State, Zip Code: _____

I understand that the Protected Health Information in my psychotherapy notes may include information relating to sexually transmitted diseases, family planning, treatment for substance use disorders, genetic testing information and/or HIV/AIDS treatment. My check mark(s) below indicate(s) that I **PERMIT** The Dimock Center to disclose information of this type, if it exists:

I understand that I have the right to inspect and copy the information to be disclosed. I understand that my records are protected under the federal regulations governing Confidentiality in Alcohol and Drug Abuse Patients, 42 CFR Part 2; the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Pts. 160 & 164; and 105 C.M.R. 164.084, and cannot be disclosed (or re-released) without my written consent unless otherwise provided for in the regulations. I understand that this information may be released electronically (e.g. fax, email), which poses a risk to confidentiality. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it. If I am currently in treatment, this consent automatically expires within 30 days after treatment termination or upon receipt of payment for treatment services rendered, whichever is longer. If I am currently in treatment, this authorization expires within 90 days of the date of my signature unless otherwise noted.

Information to release: (check the appropriate boxes and include other information where indicated)

Dates of treatment being requested (indicate specific dates or date range): _____

☐ **Complete Psychotherapy Notes** ☐ Psychiatric Records of information ☐ Substance Use Treatment Records
☐ Sexually Transmitted Diseases (STDS) ☐ Social Work Counseling/Therapy ☐ Professional services of a licensed psychologist
☐ Massachusetts Sexual Assault Evidence Collection Kit/Sexual Assault Counseling

Reason for release:
☐ Personal Use ☐ Legal ☐ Continuation of Care/Medical
☐ Other (Please Specify) _____

PLEASE NOTE: This authorization is to be used for the purpose of releasing psychotherapy notes. This authorization is not to be used to disclose any other type of Protected Health Information, however there may be references to other health care providers and/or treatment within the psychotherapy notes.

RELEASE INFORMATION TO (if not patient)

Name: _____

Address: _____ E-mail Address: _____

City, State, Zip Code: _____ Phone Number: _____

Purpose for disclosure: _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Center. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurance with the right to contest a claim under my policy.

This authorization will expire automatically in six months from the date on which it was signed or on the following specified: ___/___/_____. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

I understand authorizing the disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment.

Signature of Patient: _____ Date: _____

Relationship to patient, if other than patient: _____

Witness: _____ Date: _____