U of L Campus Health Services
Authorization for Release of Psychotherapy Records

HSC OFFICE 502-852-6446 FAX 502-852-6649 401 E. CHESTNUT STREET, STE 110 LOUISVILLE, KY 40202
BELKNAP OFFICE 502-852-6479 FAX 502-852-0660 215 CENTRAL AVE., SUITE 110 LOUISVILLE, KY 40208

Please send a copy of this release with the requested records.

Section 1. PATIENT INFORMATION: (Please print)			
Patient Name	Date of Birth	Student ID Number	
Address	City	Zip	Phone

Section 2. RELEASE FROM: [Name of physician or facility releasing information]			
Physician/Facility			
Address	City/State	Zip	Phone: Fax:

Section 3. RELEASE RECORDS TO: **The authorized person/entity to request & receive the information in this authorization**		
Physician/Facility SELF—PLEASE INITIAL_____		
Address		Phone: Fax:
City/State	Zip	Phone: FAX:

	Complete Chart		Labs Only
	Medication History Only		Other (specify)
	Progress Notes Only		

Pursuant to the Health Insurance Portability and Accountability Act (HIPPA), 45 CFR §164508, the provider listed above is hereby authorized to release to the University of Louisville Campus Health Services Office all ***psychotherapy notes—non-redacted*** which you have concerning me.

I have reviewed and understand the following:

- I understand that, if my health information is disclosed to someone who is not required to comply with federal privacy regulations, then that information could be re-disclosed
- I understand that I may revoke this authorization at any time by writing a letter to this office. I understand that my revocation cannot affect those who were already authorized to use/disclose my protected health information, according to this authorization, prior to my revocation.
- I understand that I do not have to sign this authorization as a condition of treatment or payment by this office.
- The protected health information being used and/or disclosed under this authorization is for the following purpose (leave blank if releasing to yourself)
- I understand that I may receive one copy per year of my medical record at no charge from the sending facility. Furthermore, I understand that the sending facility may charge me for subsequent copies provided during that 12 month period
- HIPPA provides special protections to certain medical records known as "psychotherapy notes". Psychotherapy notes are defined under HIPPA as note recorded by a health care provider who is a mental health professional documenting and analyzing the contents of conversations during a private counseling session or a group, joint or family counseling session that are separated from the rest of the individual's medical record, excluding medication prescription and rnonitoring, counseling session start and stop times, modalities and frequencies of treatment furnished and any summary of the following items: diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date.
- Psychotherapy notes, therefore, differ from "mental health records" as defined under Kentucky law. In order for a medical provider to release "psychotherapy notes" to an attorney or other third party, the patient who is the subject of the psychotherapy notes must sign a HIPPA compliant authorization to release other medical records; therefore, two authorizations form must be signed by the patient in order for the provider to release medical records and psychotherapy records.
- Unless otherwise revoked, this authorization is valid for 180 days from the date signed or on the following date or event _____

_____ _____
Patient or Guardian's Signature Date

_____ _____
Witnessed Signature Date