

Releasing Information

There are 3 kinds of release situations now: our original Release of Information and it's uses under Colorado Law and Professional Ethical Standards; HIPAA's Consent to release information for treatment, payment, and operations purposes; and, HIPAA's Authorization to release of psychotherapy notes and for non-treatment, non-payment, and non-operations activities. When the client signs your Notice of Privacy Practices, they are giving blanket consent to release information for treatment, payment, and operations purposes, and no further written consent is required by HIPAA. Practitioners need 2 forms for the release of information, a Release of Information form and a HIPAA compliant Authorization to release information form, and must become familiar with when to use which form of release. Or, they may adapt their Release of Information form to become a HIPAA compliant Authorization form.

Colorado law and our Professional Ethical Standards are more stringent than HIPAA about obtaining a written release for treatment purposes, and these standards should be followed. For instance, when sharing information with a physician medicating or treating our client, we continue to obtain a written Release of Information even though HIPAA allows us to release information without a written Authorization because the release is for treatment purposes. However, when releasing information to an attorney, we must obtain a HIPAA compliant Authorization, because it is not a treatment, payment, or operations activity.

A HIPAA compliant Authorization must have 10 elements, and the client must be given a copy.

1. A specific description of information to be disclosed.
2. Name of person authorized to release the information.
3. Name of person authorized to receive the information.
4. A description of each purpose of the requested disclosure.
5. An expiration date or event.
6. Signature of the client or legal representative.
7. A statement that the client has a right to revoke the authorization, in writing.
8. A statement that the client's treatment or payment could not be conditioned on their permission to release private information.
9. A statement of the potential for re-disclosure of the information by the recipient.
10. The form must be written in plain language.

A Release of Information should contain all of these above elements except for number 8. It is not necessary, and maybe not even desirable in some instances, to state that treatment will not be conditioned on the permission to release information. For instance, you may need hospital records in order to diagnose or plan treatment for a client.

A non-complying Release of Information form is acceptable when the request is from and for another provider's treatment, payment, or operations activities. It is also acceptable for releasing information for treatment, payment, and operations purposes covered under the HIPAA consent provision.

[Your Practice Name]

Authorization For Release of Information

I, _____, hereby authorize [Your name or Practice] and
Client
_____, at _____ to exchange information.
Name Telephone

The type of information to be disclosed:

Evaluations _____	Medical/Hospital Records _____
Diagnosis _____	Psychological/Medical Test Results _____
Treatment Plan _____	Mental Health Record Summary _____
Course of Treatment _____	Psychotherapy Notes _____
Other _____	

The purpose of such disclosure:

Ongoing Treatment _____	Medical Care _____	Consultation _____
Evaluation _____	Transfer _____	Legal issues _____
Coordination of Care _____	Health Benefit Utilization _____	Other _____

Exceptions: _____

The designated information about me () may () may not be transmitted by fax, electronic mail or other electronic file transfer mechanisms. [Your name] and the above designated person () may () may not discuss by telephone the content of the information released.

This consent is in effect until _____. I understand that I may revoke this authorization, in writing, at any time unless action based on it has already take place.

I hereby release all parties stated herewith from any liability resulting from the release of this information. I agree that a photocopy of this release shall be as valid as the original.

I understand that my communications in therapy are protected under federal and state confidentiality regulations and cannot be disclosed without my written authorization. The information provided by a client during therapy sessions is legally confidential in the case of licensed clinical social workers, except as provided in section 12.43.218 CRS and except for certain legal exceptions. In general, these exceptions pertain to matters of danger to self or others, and to assault or neglect of children.

I further understand that the potential exists for re-disclosure of my private mental health information, and that it may no longer be protected under the HIPAA privacy regulations.

This is to certify that I have given consent freely and voluntarily, and that the benefits and disadvantages of releasing the information, if known, have been explained to me.

Date

Signature of Client or Personal Representative

FEDERAL REGULATIONS PROHIBIT THE RECIPIENT OF THIS INFORMATION FROM MAKING ANY FURTHER DISCLOSURES OF THIS INFORMATION.

This authorization to disclose private health information is for the release of psychotherapy notes or purposes other than my treatment, payment or the related operations of the practice, and I understand that my authorization, or refusal, will not affect my ability to get treatment or payment. However, the Practitioner can condition those things (1) if the my treatment is related to research, or (2) if my treatment is being provided to me solely for the purpose of creating protected health information for disclosure to a third party.

By my signature below, I acknowledge a receipt of this disclosure.

Date: _____

Signature of Client or Personal Representative

Note: This form may be used for a release of information when HIPAA compliancy is not required but our practice standards are to obtain a written release, by using page one only. The second page (which can be the backside of the first page) makes this a HIPAA compliant authorization for use when the release is to 3rd parties and is not related to treatment, payment, or operations activities. Since psychotherapy notes are so sensitive and enjoy extra protection under HIPAA, it is advisable to use the following form for authorization to release psychotherapy notes. Remember, they must have a separate authorization form, and cannot be included on authorizations to release other information.

[Your Practice Name]

Authorization for Use or Disclosure of Psychotherapy Notes

I, _____, hereby authorize _____ and his/her staff
Client Name

to use or disclose the psychotherapy notes described below to the persons and for the purposes described below:

- Description of Psychotherapy Notes to be used or disclosed by date(s) of service or other identifier:

- The persons or entities to receive the psychotherapy notes identified above:

- Purposes for the use or disclosure of the Psychotherapy Notes:

- This authorization shall be in effect until _____, at which time this authorization to use or disclose psychotherapy notes expires.

- I understand that I have the right to revoke this authorization, in writing, at any time, but that this revocation will not affect any releases made or other actions taken prior to the date of revocation. I also understand that a revocation will not be effective if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim under the policy.

- I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal law.

- I understand that [Practice Name] will not condition my treatment on whether I provide authorization for the requested use or disclosure of psychotherapy notes of my treatment, except (1) if my treatment is for use or disclosure in research, or (2) my treatment is being provided to me solely for the purpose of creating protected health information for disclosure to a third party, and the use or disclosure is for that third party.

I acknowledge that I have received a copy of this authorization to use or disclose psychotherapy notes.

Date: _____

Signature of Client or Personal Representative

Note: If you prefer, you may use this as a separate Authorization form for information not included under the HIPAA Consent policy, i.e. for other than treatment, payment, or operations releases. You would then use the first page of the Release of Information form to cover treatment, payment, or operations information released, but where the standard of care has been to get a signed release. This HIPAA compliant Authorization form is not necessary to release information for treatment or payment purposes except if the information to be released is psychotherapy notes or certain research information.

[Your Practice Name]

Authorization For Disclosure

I hereby authorize the use or disclosure of my protected health information (PHI) as described below. I understand that this authorization is voluntary. I understand that, if the person or organization authorized to receive my private health information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Client name: _____ Identifier: _____

Persons/organizations authorized to release your PHI: _____ Persons/organizations authorized to receive your PHI: _____

Specific description of PHI to be released (including date(s)): _____

Specific restrictions you want placed on release of your PHI: _____

I understand that this authorization will expire on _____, or when (specify) _____

I understand that I may revoke this authorization at any time by notifying the releasing organization in writing, but my revocation will not affect any releases made or other actions taken before the date of my revocation.

(To be completed by Practitioner before signature by Client)

_____ Request for Own Use _____ Request for Use and Disclosure by another Provider/Plan
The use or disclosure for which this request is made is _____

(To be completed by Client before signing)

I understand that I am not required to sign this authorization form.
I understand that my health care and the payment for my health care will not be affected if I do not sign this form.
I understand that I will receive a copy of this form after I sign it.

Signature of Client or Personal Representative (*Form MUST be completed before signing.*) **Date**

[Your Practice Name]

Re:
Date of Birth:
SS #:

Consent to Release Confidential Information to an Insurer

Dear Sir or Madam,

This form authorizes [your name] to release information from her/his record maintained while I was a client of [your name] from _____ to _____. The information to be disclosed is:

- _____ that needed to complete a required report
- _____ a letter or statement containing dates of treatments(s) and a diagnosis
- _____ a summary of treatment and progress
- _____ other:

This information is to be sent to my identified insurance carrier or its agents:

This information is needed for the following purpose(s):

- _____ Health insurance benefits, reimbursements, payment for related services or other similar decisions
- _____ Life or other insurance application, payments or other decisions
- _____ Other: _____

The designated information about me () may () may not be transmitted by fax, electronic mail, or other electronic file transfer mechanisms. (your name) and the designated recipient () may () may not discuss by telephone the content of the information released.

I understand that, by law, I need not consent to the release of this information. This information is not required for my treatment. However, I willingly choose to release it for the purpose(s) specified above. I understand that I may revoke this release at any time except to the extent that action has been taken in reliance on my consent.

Also, please note the following points:

a. This information has been disclosed to you from records whose confidentiality is protected by state and federal law. HIPAA and Federal regulations (42 C.F.R. section 2.31 (a) and 2.33) and state regulations prohibit you from making any further disclosure of it without the specific written authorization of the person to whom it pertains, or as otherwise permitted by such regulations.

b. This is strictly confidential material and is for the information of only persons who are professionally capable of understanding, appreciating and acting upon it using their specific and advanced professional training in the mental health field. No responsibility can be accepted by the practitioner if it is made available to any other person or persons who lack such training, or who would not treat it in a professionally responsible manner, or who otherwise should not have access to it, including the patient.

c. Re-disclosure or re-transfer of these records is expressly prohibited and such re-disclosure may subject you to civil liability.

d. Federal and State rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Assignment of Health Insurance Benefits

My signature authorizes the payment, directly to [your name], of benefits payable under my policy. I understand such payments will be credited to my account with [your name]. I further understand that I am financially responsible to [your name] for charges not covered or reimbursed by my policy up to the fee [your name] has agreed to accept.

Medicare Patients only

I request that payment of authorized benefits be made to [your name] on my behalf. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits or the benefits payable for related services.

An individually signed photocopy of this release is to be considered as valid as the original.

Signature: _____ Date: _____
Client or Personal Representative

____ Copy accepted by releaser

____ Copy refused and kept by practitioner