Charleston Area Medical Center

PLACE
PATIENT IDENTIFICATION LABEL
HERE

MRO/CAMC Release of Information
130-138 57th Street, SE
Charleston, WV 25304
Phone: (304) 388-1308
Fax: (304) 388-1195

Scan to: BH Confidential ROI

# AUTHORIZATION TO DISCLOSE PSYCHOTHERAPY NOTES

**PATIENT NAME**: _____ **DATE OF BIRTH**: _____
[Please print full name]

**Last 4 SSN:** _____ **DAY PHONE**: _____ **OTHER NAMES USED:** _____

**PATIENT ADDRESS:** Street:_____City: _____ State: _____ Zip: _____

**Psychotherapy Note Information Requested: (Complete options below)**

**Date(s) of Service Requested:** _____

**METHOD OF RELEASE:** ****Complete mailing address is required. **** **Incomplete form will be returned to requester.**

**Person/Facility to Receive Information:** _____

Check the method of preferred delivery:

☐ Mailed to: ***STREET:*** _____ ***CITY:*** _____ ***STATE:*** ____ ***ZIP:*** _____

☐ **Fax Number:** _____

☐ **Email Address (Patient requests only):** _____

**Charleston Area Medical Center (CAMC) will transfer information to the email address of your choosing. However, CAMC is not responsible for any potential risks and/or consequences if you choose to use an unsecure email address.

**Purpose of Disclosure:**

☐ Continuity of Care ☐ Insurance ☐ Litigation ☐ Worker's Compensation
☐ Disability Determination ☐ Personal ☐ Other (Please specify): _____

**Authorization to Release Information:**

1. I understand that, by signing this Authorization to Disclose Health Information, I am giving my permission for CAMC to disclose psychotherapy notes as defined in the Health Insurance Portability and Accountability Act (HIPAA) for all dates of service as specified above. I further understand CAMC is not legally obligated to provide a patient with access to psychotherapy notes. Depending on your provider's decision, you may receive a summary.

**Other Special Instructions, if any:** _____

2. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment, payment, enrollment in a health plan, or eligibility for benefits unless I have agreed to receive the treatment as part of a research project or in order to provide my information to a third party. Under those circumstances, I understand that my refusal to sign may result in CAMC's refusal to treat. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the HIM Department at 304-388-1308.

3. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to Privacy Officer at the address listed above. 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 insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire 180 days from the date of signature. If applicable, insert another date or event of expiration: _____

4. I understand that I will be given a copy of this authorization form upon request. Furthermore, I understand that charges for record production, regardless of media used, will be applied according to State/Federal Law, and pre-payment may be required. Records mailed directly to a provider will not be subject to a charge. A third party vendor has been contracted to provide this service and will invoice you directly.

**All requests are processed within 30 DAYS of receipt as permitted by State/Federal Law**

**Signature of Patient or Legal Representative**_____ Date: _____

If signed by legal representative, relationship to patient: _____

For Provider Use Only

☐ Approve

☐ Deny

Provider Signature _____ Date _____

Provider Notes _____

_____

_____

_____