EMERALD COAST COLLABORATIVE SOLUTIONS
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Patient Rights and HIPAA Authorizations

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").

1. Tell your mental professional if you don't understand this authorization, and they will explain it to you.
2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to your mental health professional and your insurance company, if applicable.
3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment, or affect your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program, or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.
4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.
5. If this office initiated this authorization, you must receive a copy of the signed authorization.
6. HIPAA provides special protections to certain medical records known as "Psychotherapy Notes". All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional (such as a psychologist or a psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and are separate the rest of the individual's medical records. Excluded from "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

In order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from attached to release other medical records.

My signature indicates I have been offered a copy of Patient Rights and HIPAA Authorizations.

Signature: _____ Date: _____

Only complete authorization to release information if applicable.

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Authorization to Release Information

Section I – Patient Information

Name:	Member ID:
Street Address:	Birth Date:
City:	State: Zip:
Telephone:	Email:

Section II – Authorized Designee (to whom the information will be sent)

Name:	Relationship:
Street Address:	Telephone:
City:	State: Zip:

Section II B – I hereby authorize _____
to release my medical record.

Section III – Specific Information to be Released:

□ Please release my Medical Record from (insert date) _____ to (insert date) _____.

□ Please release my entire Medical Record, excluding psychotherapy notes, billing records, and insurance records.

□ Other: (Please explain) _____.

Reason for release of information:

□ At the request of the individual

□ Other: _____.

This authorization will be in effect for one year from the date signed, unless you indicate a shorter period below:

Date on which this authorization will expire: _____.

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to mental health treatment, excluding psychotherapy notes.
2. If I am authorizing the release of mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law.
3. I have the right to revoke this authorization at any time by writing to Emerald Coast Collaborative Solutions. I understand that I can revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment will not be conditioned upon my authorization of disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient, and the redisclosure may no longer be protected by federal or state law.
6. This authorization does not authorize you to discuss my personal health information and insurance record with anyone other than the person authorized.

By signing this form, I am confirming that it accurately reflects my wishes. In addition, I have kept a copy of this form for my records. In the case of a minor child, signature of authorized guardian.

If an authorized representative is making this request, please provide your information below and attach certifying documentation of your status as the authorized representative, such as Power of Attorney or Guardianship papers.

Print Name: _____

Signature: _____

Date: _____

Authorized Representative

Name:	Relationship:
Street Address:	Telephone:
City:	State: Zip:

Important Warning:

This message is intended for the use of the person/entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this information is strictly prohibited. If you have received this message by error, please notify us immediately and destroy the related message.