TULANE UNIVERSITY MEDICAL GROUP AUTHORIZATION FOR THE RELEASE OF PSYCHOTHERAPY NOTES

This form must be fully and completely filled out to be valid.

PATIENT AND RECIPIENT'S INFORMATION

I hereby authorize Tulane University Medical Group to release the information checked (X) below (which includes Protected Health Information) on the patient listed below to the recipient identified below.

THE RECORDS OF: *(Patient's Information)*

Name: _____

DOB (MM-DD-YYYY): _____

Address: _____

Phone: _____

DELIVER TO: *(External Entity)*

Name: _____

Address: _____

Phone: _____

FAX: _____

☐By checking the box you authorize the two-way exchange of your information between the above parties.

PURPOSE OF DISCLOSURE – *Not required for request by patient or personal representative*

- ☐ Medical
- ☐ Insurance
- ☐ Legal
- ☐ For case management and care coordination, including for coordinating supportive services for the patient.
- ☐ Other:

SPECIFIC TREATMENT PERIODS

Specific treatment date or time period for which disclosure is authorized:

- ☐ Single treatment date of _____.
- ☐ Period of treatment from _____ to _____.
- ☐ Any and all treatment encounters to date.

DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED

Specific description of information to be disclosed.
To authorize the disclosure of psychotherapy notes, this form entitled Authorization for the Release of Psychotherapy Notes must be completed.

☐ Psychotherapy Notes

This authorization will expire on the earlier of the following date or occurrence: (1) _____, (2) the date I revoke this authorization in writing, (3) one year from the date I signed this authorization, or (4) if signed on behalf of a minor, when the minor turns 18 or becomes emancipated under Louisiana law.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My health care provider may not condition my treatment, or payment for my treatment, on whether I sign this form.
3. I may revoke this authorization at any time in writing by sending notice to: HIPAA@tulane.edu or Tulane University Privacy Office, 1441 Canal St., Ste 424, New Orleans, LA 70112. I understand that my revocation shall not be effective to the extent this authorization has already been relied upon.
4. Medical records and other information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws and regulations.
5. I am entitled to receive a copy of this form after I sign it if Tulane University Medical Group has requested this form be signed.

SIGNATURES

I have read the above and authorize the disclosure of the Protected Health Information as stated. By signing this authorization, I affirmatively represent that either I am the patient or that the patient is alive and I am legally authorized to make his or her healthcare decisions, including release of medical records.

Signature of Patient/Personal Representative:	Date:
Print Name of Patient's Personal Representative (*Authority document must be attached*):	Relationship to Patient (if not Patient)