Authorization for the Release of Psychotherapy Notes

Important Notice: Any release of psychotherapy notes MUST be approved
by the Behavioral Health Provider.   The Provider can choose to deny any request.

Behavioral Health Provider Approval: ________________________ Date: _______________

Patient Demographics:

Patient Last Name ______________________________ First Name ______________________ MI______

Patient Date of Birth _________________________________

Patient Address ____

Authorization

Note: All references below to 'patient' are for the patient listed above.

I give my permission for Northampton Area Pediatrics to share my/ the patient's psychotherapy notes with the person or organization listed below.
Choose One:

- ☐ All psychotherapy notes
- ☐ Psychotherapy notes for the period from _____________to _________________

Share a copy of my/ the patient's psychotherapy notes with:

Name ____

Organization ____

Address ____

Email Address ____

Phone ___________________________________ Fax _______________________________________

I know I can revoke this form at any time. This means I can tell Northampton Area Pediatrics to stop sharing my/ the patient's information. I know I cannot withdraw information that Northampton Area Pediatrics had shared before I told Northampton Area Pediatrics to stop. Northampton Area Pediatrics may already have shared it. If I no longer want my/ the patient's medical record shared I will send a written letter to Northampton Area Pediatrics telling them to revoke this form.

This approval will end in 12 months or sooner if I send a written letter to Northampton Area Pediatrics telling them to revoke this form.

Cont.

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By signing below, I agree that I understand the above. I am voluntarily allowing my/ the patient's medical record to be shared.

____

Patient's Name

____________________________________ ____________________________________

Parent/Legal Guardian's Name (if applicable) Relationship to Patient

____ ___________________

Signature of Parent /Legal Guardian /Self (if 13+) Date

Patients under the age of 18 may be allowed to provide or decline release without parental consent under Massachusetts law.

Important Notice

You do not have to give permission to share these records. Northampton Area Pediatrics will not base your/ the patient's treatment on whether or not you sign this form.

After your/ the patient's medical record is shared, this information may be re-disclosed (shared) by the person or organization you listed above. This re-disclosure may not be protected by State and Federal law.

You have the right to get a copy of this signed form.

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