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Pediatric and Adolescent Medicine

Authorization to 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.

NAP Behavioral Health Provider Approval Signature: _____ Date:_____

Patient Name: _____ **Date of Birth:** _____

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

Name/Facility: _____

Address: _____

Phone Number: _____ Fax: _____

Email: _____

Choose One:

☐ All psychotherapy notes

☐ Psychotherapy notes for the period from _____to _____

Without my express revocation, I understand that this authorization will expire 1 year from the date signed unless indicated below:

Under the following condition(s): _____

Upon satisfaction of the need for disclosure on _____
(enter a future date other than date signed by patient not to exceed 1 year)

I may revoke this authorization in writing, but any previously disclosed information would not be subject to such revocation.

Guardian/Parent Signature: _____ Date Signed: _____

Relationship to Patient: _____

Patient Signature: _____ Date Signed: _____
(for patients 12+ yrs)

In accordance with Massachusetts teen privacy laws, patients 12 years and older must sign this form to provide consent for the release of sensitive health information.

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.