Milford Regional Physician Group Inc.
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Medical Records Fax: 508-478-0694
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AUTHORIZATION FOR USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES

This form is used to authorize the release of psychotherapy notes in accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Section 1: PATIENT INFORMATION

Name: _____ Date of birth: _____

Address: _____ Apt#:_____ City: _____ State: ____ Zip: _____

Phone: _____

Section 2: AUTHORIZATION

FROM: (Office providing the information)

Name: _____

Address: _____

_____

Phone: _____

TO: (Person(s)/Organization receiving the information)

Name: _____

Address: _____

_____

Phone: _____

Email: _____

Mail or email delivery only

Section 3: PURPOSE

The purpose for the release of this information is:

- ☐ Continuity of Care *****
- ☐ Insurance or other third party reimbursement
- ☐ Legal Matter
- ☐ At the request of the patient
- ☐ Other: (Specify)_____

*****If, for continuity of care, records needed for appointment on _____ (date) at _____ (time)

Given the sensitive nature of mental health and treatment information, please allow additional time to process this request. **ALL** requests must be approved by the provider prior to the release of any mental health documents.

Section 4: INFORMATION TO BE RELEASED

- ☐ Date(s) of service:_____
- ☐ Other:_____

***Please note: MRPG may charge a fee for records. Cost will vary depending on the requested documents. Invoices will be mailed.**

Section 5: SIGNATURE

By signing this authorization I agree that all mental health information about me including notes of my providers, results of diagnostic studies, my response to therapies that have been prescribed and other mental health related information pertaining to me can be released to the recipient stated above.

I understand that:

- I may withdraw my authorization at any time by submitting a written request to the office where I originally submitted this authorization. Authorization may be withdrawn except for the following:
  - To the extent that action has been taken in reliance on this authorization
  - If the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy
- I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected.
- Information released on this authorization, if disclosed by the recipient, is no longer protected by Milford Regional Physician Group, Inc.
- I understand that I have the right to inspect the records that I am authorizing to be released unless it has been determined by my provider that my review of the records will be a substantial detriment to my treatment or if disclosure of such information to me will reveal the identity of persons or breach the confidentiality of persons who have provided information based upon an agreement to maintain their confidentiality.
- I understand this authorization will expire upon completion of request however; the request will not be valid after 1 year.

ALL SECTIONS MUST BE COMPLETED. INCOMPLETE FORMS WILL BE RETURNED AND COULD DELAY YOUR REQUEST.

By signing below I am acknowledging that I understand the nature of this release. This form must be signed. We do not accept any typed signatures.

Patient's (or Parent) Signature: _____ Date: _____

Print Name: _____Relationship to patient: _____

Signature of Legal Representative *: _____Date: _____

*Please include legal documents if signing as patient's legal representative.