Directions Counseling Group 6797 N. High Street, Ste 350 Worthington, OH 43085
614.888.9200 tel 614.888.3239 fax

Authorization Form for Disclosure of Protected Healthcare Information
➔ Psychotherapy Notes-Form B ←

This form, when completed and signed by you or a personal representative having legal authority to execute this authorization on your behalf, authorizes me to release protected information from your clinical record to the person you designate.

I authorize: _____, or his/her administrative staff to release:

☐ Any and all psychotherapy notes ☐ A summary of my psychotherapy notes

☐ Other: (specify what part of the psychotherapy notes) _____

This information should only be released to (person to whom the information is to be released to):

Name(s): _____

Address: _____

Fax: _____ Phone: _____ Email: _____

I am requesting my clinician to release this information for the following reasons:

○ At the request of the individual is all that is required if you are my client and you do not desire to state a specific purpose check here

○ Other: _____

This authorization shall remain in effect until it expires on: _____
Or until (occurrence of specific event): _____

Requested restrictions: Therapist's response to restrictions:

You have the right to revoke this authorization in writing at any time by sending such written notification to our office address. However, your revocation will not be effective to the extent that we have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my therapist generally may not condition providing me mental health services upon my signing an authorization unless the mental health services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

I understand and acknowledge that this authorization extends to all or any part of the records designated above. I also understand that this authorization extends to release of information via U.S. Mail, overnight mail, telephone, fax machine, or computer email.

_____
Print Client Name Client SSN

_____
Address City State Zip

_____
Signature of Client/ Authorized Party/Gaurdian/Parent Date

If the authorization is signed by a personal representative of the client, a description of such representative's authority to act for the client must be provided:

Ohio Revised Code ,3701.741- Except as provided in divisions (C) and (E) of this section, a health care provider or medical records company that receives a request for a copy of a client's medical record from the client or client's personal representative may charge not more than the amounts set forth in this section. Total costs for copies and all services related to those copies shall not exceed the sum of the following:

- $2.50 per page for the first ten pages
- $.50 per page for pages eleven through fifty
- $.20 per page for pages fifty-one and higher
- With respect to data recorded other than on paper, $1.70 per page
- The actual cost of any related postage incurred by the health care provider or medical records company