CHRISTUS.
ST. VINCENT
Regional Medical Center

Authorization for Use & Disclosure of Psychotherapy Notes

Patient Identification

Printed Name: _____ Date of Birth: _____

Address: _____

_____

Telephone: (____)_____

Information To Be Released – Covering the Periods of Health Care

From (date) _____ to (date) _____

Psychotherapy Notes (specify) _____

_____

Purpose of Request

☐ Treatment or consultation	☐ At the request of the patient	☐ Billing or claims payment
☐ Treatment, payment or health care operations of *[name of facility or provider]*		

☐ Other, (specify) _____

Send / Release Information

☐ Paper ☐ CD ☐ Electronic Portal (E-mail notification when access is available)

***Please initial if you have requested your information to be sent to you in an unencrypted electronic format. _____.**

Release to Name: _____

Mail to Name: _____

Mail to Address: _____

E-mail Address: _____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that if my medical or billing records contain information in reference to drug and/or alcohol abuse and/or psychiatric treatment I have been afforded the opportunity to sign a specific authorization. ***Initial One:*** **Yes_____ No_____ Not Applicable _____**

I understand if my psychotherapy notes contain information in reference to HIV/AIDS (Acquired Immunodeficiency Syndrome) testing and/or treatment I have been afforded the opportunity to sign a specific authorization.
Initial One: **Yes_____ No_____ Not Applicable _____**

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at 455 St. Michael's Dr., Santa Fe, NM 87505 or margo.dittrich@stvin.org. Unless revoked, this authorization will expire on the following date or event _____or 180 days from the date of signature.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed.
I authorize CHRISTUS St. Vincent Regional Medical Center to release the protected health information specified above.

Signature: _____ Date: _____

Authority to sign if not patient: _____

Identity of Requestor Verified via: ☐ **Photo ID** ☐ **Matching Signature** ☐ **Other, specify** _____

Verified by: _____

245942

CHRISTUS ST. VINCENT Regional Medical Center
Santa Fe, New Mexico
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245942 (5/18)