MRN: _____

PATIENT AUTHORIZATION FOR DISCLOSURE OF PSYCHOTHERAPY NOTES ONLY

INSTRUCTIONS
Fill in the appropriate information in each applicable section. Sign and date the form. Incomplete forms will be returned to you unprocessed. A separate authorization must be completed for each request.

Patient Full Name: _____ Maiden Name: _____
Last First Initial

Date of Birth: _____ Last 4 digits SS#: _____ Sex: M/F Telephone: ( ) _____

Address: Street: _____

City: _____ State: _____ Zip: _____

I, _____ hereby authorize _____, it's director or agent, to disclose information contained in the medical record of the patient identified above, which includes information that may be stored in a paper and/or electronic format, as set forth below. This authorization is for the disclosure of psychotherapy notes only. However, such notes may contain information on general medical care; alcohol and drug abuse treatment; psychological and social work counseling; human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) or AIDS related complex (ARC); communicable diseases or infections, including sexually transmitted diseases, venereal diseases, tuberculosis and hepatitis; demographic information; and treatment received at other health care providers.

1. Name or title of person or organization and address to whom information is to be:

[X] Disclosed To: Legal Eagle Copy Service
8385 PGA drive
Suite 103
Walled Lake, MI 48390
Address

[ ] Requested From: _____
_____
_____
_____
Address

2. The purpose or need for such disclosure

___ At the request of the patient ___ Personal Use ___ Continuation of Care ___ Attorney
___ Workman's Compensation ___ Insurance ___ Disability X Other: Legal Discovery

3. The psychotherapy notes to be disclosed are for the **dates of service** indicated below.

4. This authorization is valid only if received by Henry Ford Health System within 60 days of the date signed

5. Ongoing access in treatment settings: This authorization expires when the patient information is disclosed as permitted in this authorization, or on _____ (date cannot exceed one year from the date of signature below).

6. I may revoke this authorization at any time. Revocations to this authorization must be presented in writing. Revocation will not apply to the information that has already been released pursuant to this authorization.

7. My care or treatment will not be conditioned on signing this authorization.

8. The persons to whom information is disclosed under this authorization may possibly re-disclose the information to others without the patient's knowledge or consent and therefore the privacy of personal and health information may no longer be protected by law.

9. Henry Ford Health System and/or its copying services reserve the right to charge for processing and copying information. This fee is waived when releasing information **directly** to a treating physician or health care facility.

Signature: _____ Relationship (if other than patient): _____
Patient, Parent of Minor, Legal Guardian, Personal Representative, Heir at Law, Person under a POA*

Date: _____

* If Legal Guardian, Personal Representative or Power of Attorney, a copy of appropriate documentation is necessary for release.