Client Name and Date of Birth _____

Written Authorizations & Consents to Release Health Information

Personal Health Information (PHI) is anything communicated in a psychotherapy session; and it is confidential. Your PHI cannot be communicated to anyone else without your written authorization unless the disclosure is mandated or permitted by law.

There is a distinction between ***authorization*** and ***consent*** to use or disclose PHI. [1]

Authorizations are required for disclosures of PHI that are not otherwise allowed. PHI is ***disclosed*** when it is released, transferred, has been given to, or otherwise divulged outside of therapy.

Consents are not required, but may be used for Treatment, Payment, and health care Operations (TPO). PHI is ***used*** when it is shared, examined, utilized, applied, or analyzed within therapy.

The client gives Victor Bloomberg, LCSW ❑ Supervised Intern _____❑:

(a) Consent to release information for use ❑ by the client or guardian

_____

❑ This **consent** is for the purpose of an **in-session Collateral Consultation** – it cannot involve the release of any document – the Participant for the in-session Collateral Consultation is:

_____

Name, Relationship and Purpose of In-Session Participation

(A **Collateral Consultation** is not therapy and it is not billable to insurance. Our charge to the client is the same as any other session. A **Consent** must be signed before a **Collateral Consultation** can be scheduled. This is not done on a same day basis.)

or

[1] California Association of Marriage and Family Therapists (CAMFT), "HIPAA Forms: The Three-Headed Monster" Updated August 2010 by David G. Jensen, JD, http://www.camft.org/AM/Template.cfm?Section=HIPAA1&Template=/CM/HTMLDisplay.cfm&ContentID=10367 (Retrieved April 8, 2012)

Client Name and Date of Birth _____

(b) Authorization to disclose to ❑ / Authorization to receive from ❑

Provider ❑ / Insurance ❑ / Legal* ❑

This permission can be captured by your "smart phone" camera, or it can be sent electronically via *VSee Free HIPAA Messenger* https://vsee.com/. To use it, install it on your device.

* This Psychotherapy Practice strongly discourages authorizations to release information for a legal proceeding, because it risks changing the focus of therapy away from your well-being.

This Psychotherapy Practice does not fax. You can fax at a number of local businesses, but the fax service does not protect your PHI.

The cost of printing/photocopying, mailing will be invoiced to the client and receipts provided. This Psychotherapy Practice does not use clerical staff, your therapist is the person that would produce the paper record. For that reason, the time is charged on a prorated basis as a session charge. This could be quite expensive to you. For this reason, we strongly encourage you to use *VSee HIPAA Messenger* to get an electronic copy of your record. This option shortens the time a lot, because it does not involve paper. Please note, local businesses that print from electronic files are not HIPAA compliant.

The authorized individual is:

Recipient's name and credential _____

Organizational affiliation _____

Full business address _____

Contact information (telephone / *VSee*) _____

(Line-out each item that is not applicable.)

Intake Form ❑ Dated: _____

Informed Consent ❑ Dated: _____

Financial Ledger ❑

Personal Status Inventory ❑ Dated: _____

(The list is continued on the next page).

Client Name and Date of Birth _____

Assessments ❑

Assessment Name	Date

Progress Notes and Treatment Plans ❑ Start Date: _____ End Date: _____

Consent-Authorization to Release Information ❑ Dated: _____

Discharge Summary ❑ Dated: _____

This consent/authorization expires on: _____

The purpose of this release is:

- ❑ Summary for a Personal Health Record
- ❑ Review of PHI for an insurance claim
- ❑ Review of PHI by a healthcare provider
- ❑ Make a referral to a healthcare provider
- ❑ Facilitate consultation between the LCSW/Supervised Intern and a healthcare provider
- ❑ Respond to a Court Order
- ❑ Activate protective services that are not mandated

(In addition to licensed medical practices, healthcare includes behavioral/mental health services, alcohol and substance abuse treatment and licensed healthcare professionals in residential care settings.)

Information used or disclosed under the authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Rule, but may be protected by applicable California law.

The client and the LCSW/Supervised Intern each have a copy of this authorization.

Client Name and Date of Birth _____

Revocation

This authorization may be revoked at any time. When done in session, the therapist's copy will be notated and the notation signed and countersigned. A copy will be provided to the client. When done outside of session, verbally, the revocation may be properly notated at the next scheduled session. When there is not a scheduled session, for any reason, the client is advised to follow-up any verbal revocation with a certified letter mailed to the LCSW's post office box.

Client Signature and Date:

Therapist Signature and Date:

❑ The therapist that facilitated this consent/authorization is a supervised intern.
Printed Therapist Intern Name and BBS Registration Number:

_____

_____
Reviewed by Victor Bloomberg, LCSW (Signature and Date)