



PATIENT AUTHORIZATION  
DISCLOSURE OR RECEIPT OF *PSYCHOTHERAPY NOTES*<sup>1</sup>

Patient Name \_\_\_\_\_ Medical Record # \_\_\_\_\_

Date of Birth \_\_\_\_\_ Phone # (\_\_\_\_\_) \_\_\_\_\_

Patient Address \_\_\_\_\_  
\_\_\_\_\_

Soc. Sec.# \_\_\_\_\_ (Providing your SS# is voluntary, but necessary to accurately identify your medical records Failure to provide this information will likely delay the processing of your request).

Approximate Dates of Treatment: \_\_\_\_\_

1. I authorize the following health care provider or facility to **DISCLOSE** or **RECEIVE** my patient information:

- \_\_\_\_\_ University Hospital (Inpatient)      \_\_\_\_\_ University Neuropsychiatric Institute (UNI)
- \_\_\_\_\_ Community Clinics                      \_\_\_\_\_ Sugarhouse Clinic                      \_\_\_\_\_ Madsen Clinics
- \_\_\_\_\_ Moran Eye Center                      \_\_\_\_\_ University Orthopædics Center
- \_\_\_\_\_ Huntsman Cancer Hospital              \_\_\_\_\_ Huntsman Cancer Institute
- \_\_\_\_\_ Outpatient Clinic(s): \_\_\_\_\_
- \_\_\_\_\_ Specific Provider(s): \_\_\_\_\_
- \_\_\_\_\_ Other: Name/Credentials: \_\_\_\_\_
- Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_
- Address: \_\_\_\_\_

2. Please disclose my psychotherapy notes.

3. Please indicate the purpose of the disclosure of your psychotherapy notes:  
\_\_\_\_\_.

4. If applicable, I understand that based on the dates, providers, and information I have designated above, the disclosure UUHSC makes pursuant to this authorization may include information regarding my participation in a substance abuse treatment program.

5. I understand that if the authorized recipient of this information is not a health care provider or health plan covered by federal privacy regulations, the information he/she receives will no longer be protected by these regulations,

<sup>1</sup> Note: This form is used only in very specific circumstances. Contact the HIPAA Privacy Office about its use.  
1.4P Form - Authorization Psychotherapy Notes.doc  
Rev: 08/12/2005

and the recipient may re-disclose the information. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

6. I understand that the University of Utah Health Sciences Center will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I may inspect or copy any information used or disclosed under this authorization.

7. I understand that I may revoke this authorization in writing at any time by sending a written revocation of authorization to: Medical Records, 50 North Medical Drive, SLC UT 84132

I understand that my revocation is not effective to the extent that action has been taken in reliance on this authorization. This authorization expires (check one):

\_\_\_\_\_ 1 year from the date below      \_\_\_\_\_ One time disclosure only      \_\_\_\_\_ Other: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Representative      Date

\_\_\_\_\_  
If Applicable, Name of Personal Representative\*

\*Description of Personal Representative Authority:

Parent       Medical Power of Attorney

Other, explain: \_\_\_\_\_  
and attach documentation.

**Signature must be verified by UUHSC staff or must be notarized. When complete, place in patient's medical record.**

• \_\_\_\_\_  
Signature of UUHSC Staff Member      Printed Name and Employee ID#      Date

• SUBSCRIBED AND SWORN before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

NOTARY PUBLIC

Residing in \_\_\_\_\_

My Commission expires: \_\_\_\_\_

**UUHSC Internal Use Only**

Staff Member Processing Request's Name and Employee ID: \_\_\_\_\_

Date Received: \_\_\_\_\_

Date Sent to Patient: \_\_\_\_\_

A 30 day extension as been requested. Reason: \_\_\_\_\_

Patient Notified of Extension On: \_\_\_\_\_

Request Processed by (Name and Employee ID): \_\_\_\_\_

Fee Charged (if any): \_\_\_\_\_