Authorization for Use/Disclosure of Psychotherapy Records

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize Roger Ludwig, PC, (PO Box 389 Ranchos de Taos, NM 87557) to use or disclose the following information from

 \_\_\_\_\_ my medical records and/or psychotherapy notes

 \_\_\_\_\_ my minor child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_’s medical records and/or psychotherapy notes as described below and in accordance with the conditions set forth below:

1. Disclosure is to be made to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

2. Information to be disclosed (please initial):

\_\_\_\_\_ Verbal discussion

\_\_\_\_\_ Medical records (which includes identifying information, symptoms, diagnosis, treatment plan, session dates, prognosis, progress, medications, test results but excludes psychotherapy notes).

\_\_\_\_\_ Psychotherapy notes, which are my records of counseling session contents from the dates \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ through \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

\_\_\_\_\_ Written report summarizing the relevant portions of medical records and psychotherapy notes to date.

3. The purpose for the disclosure is

\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ is simply at my request.

4. This authorization will expire on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

5. I understand that I have the right to revoke this authorization, in writing, at any time by sending notice to Roger Ludwig, PC. I understand that a revocation is not valid to the extent that Roger Ludwig, PC has acted in reliance on such authorization.

6. I understand that there is a potential for re-disclosure of this information by the recipient and, if that occurs, the information may not be protected by federal law.

7. Roger Ludwig, PC will not condition payment or treatment on my signing of this authorization.

8. I understand that I will

\_\_\_\_\_ not receive a copy of the information released.

\_\_\_\_\_ will receive a copy of the information released.

9. I understand that I have the right to receive a copy of this form after I sign it.

10. A photocopy or facsimile of this signed authorization form shall be considered as valid as an original.

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (printed) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_