Christina L. Gmyr, Licensed Mental Health Counselor, PLLC
Mental Health Therapist
12 W. Genesee Street, Baldwinsville, NY 13027
(315) 228-0866
counseling@christinagmyr.com

Authorization for Use or Disclosure of Protected Health Information

Client's Name (First, M.I., Last):	Sex:	Date of Birth: _____ Date of Authorization:

This authorization must be completed by the patient or his/her personal representative to use/disclose protected health information (for other than treatment, payment, or health care operations purposes), in accordance with State and federal laws and regulations. A separate authorization is required to use or disclose confidential HIV related information.

Authorization Initiated By (Name - Client, Provider or Other):

Description of Information to be Used/Disclosed:

☐ Psychosocial/Intake Assessment
☐ Treatment Plans
☐ Summary of Progress
☐ Attendance
☐ Discharge Summary
☐ Psychotherapy Notes ONLY
☐ Psychological Testing
☐ Psychiatric Assessment
☐ Medical Records
☐ Court Documents
☐ Records from Alcohol/Drug Treatment Programs
☐ All verbal/written information related to treatment
☐ Other (please describe):

Purpose of Disclosure:

☐ My request ☐ Coordination of Care ☐ Assessment of Needs ☐ Treatment Planning
☐ Other (please describe):

I authorize the release of my Protected Health Information as follows:
☐ Christina L. Gmyr, Licensed Mental Health Counselor, PLLC release to name or facility below
☐ Name or facility below release to Christina L. Gmyr, Licensed Mental Health Counselor, PLLC

_____ _____ _____ _____ _____	Christina L. Gmyr, Licensed Mental Health Counselor, PLLC Mental Health Therapist 12 W. Genesee Street Baldwinsville, NY 13027 (315) 503-1151

This authorization will expire:
☐ When acted upon (one time use)
☐ When I am no longer receiving services from Christina L. Gmyr, Licensed Mental Health Counselor, PLLC
☐ One year from this date
☐ Other:

Authorization and Signature: I authorize the release of my confidential protected health information, as described in my directions above. I understand that:

1.) This authorization is voluntary.
2.) Only this information may be used and/or disclosed as a result of this authorization.
3.) This information is confidential and cannot legally be disclosed without my permission.
4.) If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be re-disclosed and would no longer be protected.
5.) I have the right to revoke this authorization at any time. My revocation must be in writing on the form provided to me, shown below. I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization.
6.) I have a right to inspect and copy my own protected health information to be used and/or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 CFR §164.524)

_____	_____	_____
Name (please print)	Signature	Date
_____	_____	_____
Parent/Guardian	Signature	Date
Christina L. Gmyr, LMHC, NCC__	_____	
Witnessed by	Witness Signature	

I hereby revoke my authorization to use/disclose information indicated above to the Person/Organization/Facility/Program whose name and address is:

_____

_____

_____

PATIENT RIGHTS AND HIPAA AUTHORIZATION

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").'

1. Tell your mental health professional if you don't understand this authorization and she will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to your mental health professional and your insurance company, if applicable.

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment, or affect your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program, or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.

5. If this office initiated this authorization, you must receive a copy of the signed authorization.

6. ***Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes.*** HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c the modalities and frequency of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

   In order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical records.