636 Saint Anne St., Rapid City, SD 57701 PH 605.348.8000 FAX 605.348.4315 or 605.413.1560 FIN 46-0446577

Request for Release of Psychotherapy Notes & Authorization

Today, (date) _____, I, _____, hereby request and

Authorize the following actions be taken for ( ) myself, or my ( ) son, ( ) daughter, ( ) _____
Other Legal Relationship

Named: (first) _____ (MI) ____ (last) _____with

Date of Birth: _____/_____/_____ and/or Social Security: _____-_____-_____.

Release of Records: From and To:***Manlove Psychiatric Group, P.C.*; DBA: Manlove Brain and Body Health (MBBH)**

Release of Records: To and From: _____
Name

_____
Address – City – State – Zip - Telephone - Fax

I hereby request and explicitly authorize the mutual exchange of any and all MBBH Psychotherapy Notes and/or other similar records between both of the named parties, as indicated below, to be used in providing care or benefits. When the requested data and material is forwarded to MBBH by your medical practitioner, this shall serve as your medical practitioner's consent in regard to releasing the requested information to MBBH, and to others as deemed necessary unless any objection thereto is received. I understand that I do not have to sign this form. Failure to do so may not result in loss of care.

This information shall include: <u>You MUST initial only those items that apply</u>….

___Psychiatric Evaluations ___Psychological Evaluations ___Psychotherapy Evaluations ___Appt. Info

___Psychiatric Treatment Notes ___Psychological Treatment Notes ___Psychotherapy Notes ___Acct. Info

___Letter ___Verbal/Phone ___Verbal exchange **<u>ONLY</u>** ___Other_____

___All of the Above

I understand that my PHI may be protected under the federal regulations governing HIPAA and/or Confidentiality of Alcohol and Drug Abuse Patient Records, 42CFR Part 2, and cannot be disclosed without my written authorization unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that actions have been taken in reliance on it, and that this **<u>consent is in effect for two years from date signed by the patient or legal guardian, unless revoked</u>**.

It is very important for you to know that some things, by law, cannot be kept private. The exceptions to confidentiality are as follows, including but not limited to: If we, or others, are ordered to testify in, or provide documents to, a Court of Law, we may have to give information regarding your case without your permission. If we, or others, learn that harm has been done to a child or an elderly person, we may be required to inform the authorities. If we or others learn that someone or something might be seriously harmed in the future, or that a patient intends to commit an act of violence, it may be our, or others, responsibility to protect you, or others, by informing them and the authorities. MBBH prohibits the re-release of our records by a third party. It is possible, however, that pursuant to the authorized release of records, that the third party, without our knowledge, may release those records to a fourth party. In this situation, the records may no longer be protected by HIPAA.

This release may be copied/faxed for use with the full force and effect of the original. I understand that I have a right to receive a copy of this authorization and the PHI released upon my request. If you have further questions, please consult the *MBBH Notice of Information Practices* or information concerning your rights. I must contact MPG to obtain the necessary form to revoke this authorization**.**

I certify that I understand the above information and believe myself to be legally competent and authorized to execute this authorization.

Signature of Patient or Legal Guardian: _____ **Date:** _____
(If Legal Representative has signed, a verifiable copy of the Court Order MUST be attached for Request to be valid.)

Witness: _____ **Date:** _____

636 Saint Anne St., Rapid City, SD 57701 PH 605.348.8000 FAX 605.348.4315 or 605.413.1560 FIN 46-0446577

Received by MPG on _____ by _____. Release #: _____
Revised 1/1/2017

For MBBH Use Only:

Failure to Obtain Authorization **Check the appropriate reason:**

□ Indirect treatment relationship □ Release Required by Law
□ Substantial Barriers in Communication □ Other
□ Verbal Request (at least 2 signatures required)

Description of Circumstances:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Staff Signature: _____ Date: _____

Witness: _____ Date: _____

Witness: _____ Date: _____