

**INDIVIDUAL AUTHORIZATION FORM  
PSYCHOTHERAPY NOTES**



**Please complete all sections of this form, and mail it to your local plan at the address shown on the back of your health plan ID card.**

**Section A: Information About the Individual Providing Authorization to Release Information**

Each individual member providing an authorization must complete a separate form.

Name: \_\_\_\_\_ Date of Birth (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Address: \_\_\_\_\_ Social Security Number: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
Member ID (on health plan ID card; include all letters and numbers): \_\_\_\_\_ Group Number (on health plan ID card; include all letters and numbers): \_\_\_\_\_

**Section B: Person/Company Allowed to Release the Information**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Company/Agency/Facility Name (if applicable): \_\_\_\_\_ -  
\_\_\_\_\_

**Section C: Person/Company/Agency or Facility Allowed to Receive the Information**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Company/Agency/Facility Name (if applicable): \_\_\_\_\_  
\_\_\_\_\_

**Section D: The Information Being Released**

By completing this form, you authorize the use and disclosure of your psychotherapy notes to the person or entity named in Section C. Due to the highly sensitive nature of psychotherapy notes, federal law requires this special individual authorization. Psychotherapy notes include, but are not necessarily limited to, notes taken by your psychotherapist in the course of or relating to your diagnosis or treatment. If you wish to release other protected health information, please complete the Individual Authorization Form.

Date(s) of the information (if applicable): \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_ or \_\_\_\_\_

**Section E: Reason for the Release of Information (check only one)**

- At the request of the individual named in Section A; or
- Other: Please state the other purpose for release of the information:

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

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**Section F: Expiration Date**

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If not previously revoked, this authorization will terminate on the earliest of the following dates:

- (1) The date the member's health coverage ends (only if disclosure is requested by the insurance company); or
- (2) One year from the signature date below; or
- (3) Upon the following date, event\* or condition\*: \_\_\_\_\_

*\*For authorization to terminate due to an event or condition, the party identified in Section B must be notified **in writing** upon occurrence of the event or condition.*

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**Section G: Signature**

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I understand that member enrollment in a health plan, eligibility for benefits, claim processing and payment; and treatment are not conditioned on my giving this authorization. A copy of this authorization is available to me, or to my authorized representative, upon request and will serve as the original. I understand that if this information is to be received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by federal privacy regulations, my information provided in this document may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations. I have the right to revoke this release of information/authorization at any time, except to the extent that the person/company has already taken action on the disclosure provisions contained in this document. If I choose to revoke the release of information/authorization, I must notify the person/company identified in Section B **in writing** that I request termination of this release of information/authorization.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this authorization is signed by a personal representative on behalf of the individual, please complete the following and attach a copy of the representative's authority to this form (e.g., Health Care Power of Attorney, Executor/Administrator of an estate):

Personal Representative's Name: \_\_\_\_\_

Relationship to Member: \_\_\_\_\_

**YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION.**