FAMILY BASED THERAPY ASSOCIATES

GENERAL AUTHORIZATION FORM FOR PSYCHOTHERAPY NOTES

NAME OF INDIVIDUAL: ______________________________ **DATE OF BIRTH:** ____________

I hereby authorize **Family Based Therapy Associates** to use, disclose, or exchange protected health information about me. The use or disclosure shall be limited to the information, persons, purposes, and timeframe described below:

INFORMATION TO BE USED OR DISCLOSED

I authorize the use or disclosure of the following protected health information created between ____/____/____ (mm/dd/yy) and ____/____/____ (mm/dd/yy) about me: (describe the information as specifically as possible)

____ Psychotherapy notes

PERSON TO USE OR RECEIVE THE INFORMATION

I authorize the following person(s) to use or receive the disclosure or the exchange of my protected health information (Name/Title/Organization):

____

____

PURPOSE OF THE REQUESTED USE OR DISCLOSURE

The protected health information may be used for each of the following purposes:

- □ At the request of the individual
- □ Coordination of county case management with counseling services
- □ Other (specify) ____

EXPIRATION DATE

This authorization will automatically expire:

- □ ____/____/____ (mm/dd/yy) (May not exceed 12 months from the date of the signature on this form); or
- □ When the following event occurs______________________________________

PLEASE NOTE THE FOLLOWING:

You may refuse to sign this authorization. Your refusal will **not** affect your ability to obtain treatment or payment. If the persons or entities authorized to receive the information are *not* health care providers or health plans covered by federal health privacy laws, they may redisclose the information and those laws would no longer protect the disclosed health information. Once you sign this authorization, we can rely on it until you revoke it or, if you have not revoked it, until it expires. You can *revoke* this authorization by delivering a dated and signed letter to our clinic addressed to:

Randall Wallace, MS, LP
199 Coon Rapids Blvd., #306
Coon Rapids, MN 55433

□ When this box is checked, our organization will receive compensation for our use/disclosure of the information that is the subject of this authorization.

Individual's (or Legal Representative's) name (please print): ______________________________

Individual's (or Legal Representative's) signature: ______________________________

Date: ______________

Capacity or authority of Legal Representative (if applicable): ______________________
(May be requested to provide verification of representative status)

Therapist's signature:______________________________ Date:______________________