UCI Health

Sharing My Mental Health Information
Plain Language-HIPAA Authorization for Disclosure of Psychotherapy

Sharing My Mental Health Information

(*Plain Language HIPAA Authorization for Disclosure of Psychotherapy Notes*)

My Information

My Name: _____ **My** Date of Birth: _____

My Address: _____ City: _____

State: _____ Zip Code: _____

My Phone number: (_____) _____-_____

My Psychologist or Therapist

My psychologist or therapy provider's office is called: _____

Address: _____

City: _____State: _____ Zip Code: _____

-My psychologist and therapy providers write notes about me regarding my treatment. These notes have personal information about me that my psychologist or therapist does not tell anyone. These notes are referred to as progress notes.
I want to share my progress notes.

-The person who can see and have copies of my progress notes is:

Name: _____

Address: _____

City: _____State: _____ Zip Code: _____

Phone number: (_____) _____-_____

Email address: _____@_____._____

Sharing My Information

This person can see:

Check one box

☐ All of my progress notes.
☐ Only some of my progress notes.

The only progress notes this person can see or have copies of are:

_____

_____

_____

This person can see my progress notes until this date:_____, or for 5 years, unless I sign a form that says this person can no longer see my progress notes.

I know that I do not have to share these records. My doctors and other health care providers will still treat me even if I don't sign this agreement.

-I know that I can stop this agreement at any time by signing a form with my doctor's office. If I stop this agreement, I know that the progress notes already shared will not be returned.

-My doctors, and other care providers have to be very careful with my progress notes. They cannot share my progress notes with other people unless I agree. The person who I am sharing my progress notes with cannot share them with other people unless I agree. If I share my progress notes with someone who is not a doctor, that person may not be required to keep my progress notes private.

-I trust the person I am sharing my progress notes with.

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My Signature:

My signature:_____

The date today is: _____

My Representative's Signature (if required)

_____Date: _____Time: _____AM/PM
Patient's Representative Signature

Relationship to Patient_____Reason for Non-Patient Signature: _____

_____ _____
Witness Signature Witness Print Name

Date: _____ Time: _____ AM / PM

If Interpreted: _____ _____ Date: _____

Time: _____ AM / PM Language

☐Telephonic ☐ Video Interpreter **or** ID#