TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER™

Department of Psychiatry
701 West 5th Street
Odessa, TX 79763
432-335-1845
432-335-1840(fax)

Authorization for Release of Psychotherapy Notes

PATIENT INFORMATION TTUHSC MRN:_____	PATIENT NAME: _____ DATE OF BIRTH:_____ Address:_____ Day Phone:_____ City:_____ State:_____ Zip:_____
RECEIVING PARTY ☐ **Send** the information to: ☐ **Receive** the information from:	NAME:_____ Address:_____ Phone:_____ City:_____ State:_____ Zip:_____
INFORMATION TO BE RELEASED (**What** do you want sent or **released**? Check the appropriate box.)	☐ Psychotherapy Note Date of Service(s) _____ **I agree that the following information may be released/used only as indicated below:** 1. AIDS/HIV test results, diagnosis, treatment, and related information Yes☐ No☐ 2. Drug screen results and information about drug and alcohol use and treatment Yes☐ No☐ 3. Mental health information Yes☐ No☐ 4. Genetic testing Yes☐ No☐
RELEASE INSTRUCTIONS (**How** do you want the information?)	☐ Electronic Form (CD/USB preferred method) ☐Paper
PURPOSE OF RELEASE (Why is it needed?)	☐Continuing Care by other health care provider ☐Disability ☐ School ☐Insurance ☐Personal review ☐Attorney/Legal ☐Other_____
To The Receiving Party Of This Information	This information has been disclosed to you for the sole purpose(s) stated in this Authorization. Any other use of this information without the express written consent of the patient is prohibited. These records may be protected by federal regulation. Federal rules prohibit you from further disclosure unless you have received written consent from the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

- This authorization is voluntary and I may refuse to sign it. My treatment or payment for services will not be affected if I do not sign this Authorization.
- This Authorization may be canceled by submitting a written notice to Texas Tech University Health Sciences Center (or the releasing facility). Information may be released until my written notice of cancellation is received.
- **This Authorization expires 180 days from the date signed or on the following date or event (specify)** _____
- Additional information is in TTUHSC's Notice of Privacy Practice.
- If the healthcare services are being provided at the request of and being paid for by my employer (or prospective employer), I understand and agree that all records and information related to the healthcare services provided to me may be given directly to my employer and if I wish to obtain such information, I must contact my employer/prospective employer.

RELEASE FROM LIABILITY: I release and agree to hold harmless TTUHSC Clinic (or other releasing facility) and its agents, representatives, employees from any and all liability associated with the release of confidential patient information in accord with the Authorization. I understand TTUHSC Clinic (or the releasing facility) cannot be responsible for use or rediscover of information to third parties.

I certify that this form has been fully explained to me, I have read it or had it read to me*, and I understand its contents.

Date	Print Your Name (**Person signing consent form**)	Patient or Legally Authorized Signature
Time	Witness/Translator *	Relationship to patient