DISCLOSURE TO RELEASE PYSCHOTHERAPY NOTES

Noetic Psychiatry

Patient Information

Patient Name:_____
(Last) *(First)* *(Middle Initial)*

Patient Social Security Number:_____ Patient Birthdate: _____/_____/_____

Email Address:_____@_____ Phone Number:(___)_____-_____

Address: _____
(Street and Apartment Number) *(City, State)* *(Zip Code)*

Recipient Psychotherapy Notes

I hereby authorize Noetic Psychiatry, it's staff, and providers to disclose my psychotherapy notes to:

Person/Organization:_____

Email Address:_____@_____ Phone Number:(___)_____-_____

Address: _____
(Street and Apartment Number) *(City, State)* *(Zip Code)*

Expiration and Revocation

This authorization will expire on the date that is **six(6) months** from the date of my signature below.

I understand that this request may be denied and that the release of psychotherapy notes is at the discretion of Noetic Psychiatry and their providers.

I understand that Noetic Psychiatry cannot condition my treatment, payment, enrollment, or eligibility for benefits on my provision of this authorization.

I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by HIPAA.

I understand that I have the right to receive a copy of this authorization.

Patient/Parent Signature:_____

Printed Name:_____ Date:_____

Relationship to Patient: [ ] Self [ ] Spouse [ ] Guardian [ ] Parent [ ] Temporary Caregiver