P: (703)-246-0011
F: (703)-246-0012
www.ChiSovereign.com

Dear Patient:

Please complete the following release form and return to us. Include your contact phone number so that we can contact you with any questions.

FEES INCURRED FOR REQUESTING COPIES OF YOUR RECORDS:

$10 processing fee
$0.25 per page
(no charge when sent to another provider or doctor)

Contact Administration at 703-246-0011 ext. 13

Fax # 703-246-0012 – ATTN: Administration

EMAIL COMPLETED FORM TO admin@ChiSovereign.com

MAILING ADDRESS:
ChiSovereign PLLC – Attn: Administration
3975 Fair Ridge Drive, Suite 150N
Fairfax, VA 22033

Please feel free to contact us with any questions.

Thank you

ChiSovereign PLLC

PATIENT AUTHORIZATION FOR USE/ DISCLOSURE OF PROTECTED HEALTH INFORMATION

I,______________________understand **CHISOVEREIGN, PLLC** is authorized by me to use or disclose my protected health information. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I specifically authorize any current employee or owner of **CHISOVEREIGN, PLLC**, or any other individual listed below to disclose my protected health information as described on this form to the recipient(s) listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization.

Description of the disclosure being requested (check all that apply):

[ ] SEND COPIES OF ALL PROGRESS NOTES:

[ ] SEND COPIES OF ALL PROGRESS NOTES FOR SPECIFIC DATES OF SERVICE: ________________________

[ ] SEND COPIES OF LAB RESULTS

[ ] VERBAL COMMUNICATION:

[ ] OTHER __________________________________

This authorization permits **CHISOVEREIGN, PLLC** to send the protected health information ONLY to this address or fax number:

Release / send to [ ]

OR

Obtain from [ ]

Name: ____

Address: ____

____

Fax: ____

Purpose(s) of the information: [ ] Transfer of Care [ ] Coordinate Care [ ] Other:___________________

This authorization shall expire on ____________________ . After this date, CHISOVEREIGN, PLLC can no longer use or disclose the patient's protected health information without first obtaining a new authorization form. If left blank, release will expire 2 years from date signed.

I fully understand and accept the terms of this authorization.

____________________________ ____________________________ ____________________________

Patient/Guardian Signature Patient Date of Birth Date

PATIENTS' RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").
Please tell us if you don't understand this authorization, and we will explain it to you.

You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to our office or your insurance company, if applicable.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment, or affect your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program, or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.

Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.

If this office initiated this authorization, you must receive a copy of the signed authorization.

Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes. HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

In order for a medical provider to release "Psychotherapy Notes" to a third party, the patient who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical records.