Think Whole Person Healthcare
Authorization to Use or Disclose Psychotherapy Notes

Patient name

DOB | SSN

I hereby authorize Think Aksarben, LLP to:

☐ Use psychotherapy notes about the above-named patient for the purposes marked below.
☐ Disclose psychotherapy notes about the above-named patient to the persons or organizations listed on the attached page for the purposes marked below.

NOTICE TO PATIENT/PATIENT REPRESENTATIVE: Information disclosed pursuant to this Authorization will be subject to redisclosure only pursuant to applicable privacy laws and regulations. Recipients of alcohol/substance abuse information are required by law to obtain your written consent before redisclosing such information.

This information is being requested for the following purpose(s):

- ☐ Assessment and Evaluation
- ☐ Treatment Planning/Continuity of Treatment
- ☐ Coordination of Community Services/Discharge
- ☐ Payment
- ☐ Patient's Request
- ☐ Treatment
- ☐ Legal Reasons
- ☐ Outside Placement
- ☐ Health Care Operations
- ☐ Other

This authorization will expire:

- ☐ 90 days from the date of the signature below, or
- ☐ Other

This authorization may be revoked by notifying Think Aksarben, LLP in writing addressed to: ,

Nick Weil, **Compliance Officer**
7100 West Center Road, Omaha, NE 68106
(402) 506-9084

Note: Protected health information may already have been disclosed before the revocation is received. If so, the revocation will be effective only as of the date it is received by Think Aksarben, LLP.

I authorize release/receipt of psychotherapy notes regarding:

- ☐ HIV/AIDS or other communicable diseases
- ☐ Alchohol and/or Substance Abuse

NOTICE TO RECIPIENTS OF ALCOHOL AND/OR SUBSTANCE ABUSE INFORMATION: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Patient Signature:	Date:
Personal Representative's Signature:	Date:
Personal Representative's Relationship/Authority	Date:

This Authorization is voluntary. If the patient refuses to sign, his/her refusal will **not** affect his/her ability to obtain treatment, payment, or, if applicable, enrollment in a health plan or eligibility for benefits. A photocopy or fax of this release shall be as valid as the original.

4838-9064-6053.4

Mandatory Attachment to Authorization

Persons or Organizations Authorized to Receive Psychotherapy Notes*

Patient name

DOB

SSN

Please include the name of the persons or organizations:, the city, and telephone number including area code.

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* Persons and organizations listed on this page are authorized to receive psychotherapy notes from Think Aksarben, LLC as indicated on the first page of this authorization. Portions of this list may be marked out to protect patient privacy.

4838-9064-6053.4