Lana Royle, MC, LCMHC
License # 8408027-6004
12401 South 450 East Suite B
Draper, Utah 84020
(801) 979-0544

PATIENT 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").

1. Tell your mental health professional if you don't understand this authorization, and she will explain it to you.

2. 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 your mental health professional and your insurance company, if applicable. Your mental health professional will be happy to provide you with a form to revoke or cancel authorization if needed.

3. 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 client in their practice.

4. Once the information about you leaves this office according to the terms of this to be aware that at that point your information may no longer be protected by HIPAA.

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

6. 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 client 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.

On page three (3) you will find a HIPPA Release Form. Though you do not need to fill one out if you do not have a need to release information to your current provider, please ask your mental health care provider for one in the future if a need should arise.

Please sign below to indicate you have been informed of your rights regarding authorizations. Lana Royle, Royle LLC will keep a copy of this for her records and provide you with a copy as well.

I have received, read, and understand "Patient Rights and HIPPA Authorizations" given to me by Lana Royle, Royle LLC. Any questions I had were answered by Lana Royle, and I am aware if I have any additional questions I may contact her to discuss.

_____

(Printed Name of Client/Parent/ Guardian)

_____ _____

(Signature of Client/Parent/Guardian) **Date**

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AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

I, _____authorize Lana Royle, MC, LCMHC to:

_____Release to:
_____Obtain from:
_____Exchange with:

_____
_____
_____

the following information pertaining to my child or myself:

_____
(client name(s))

_____ treatment summary
_____ history/intake
_____ diagnosis
_____ psychological test results
_____ educational test results
_____ psychiatric evaluation/ medication history
_____ dates of treatment attendance
_____ other (specify) _____

for the purpose of:

_____ evaluation/assessment and/or coordinating of treatment efforts
_____ other (specify) _____

I understand that I have the right to refuse to sign this form and that I may revoke my consent at any time (except to the extent that the information has already been released).

I further authorize the transmission of information over electronic mediums including email, fax and cellular telephone.

_____
_____
Signature of Client/Parent/Guardian Date