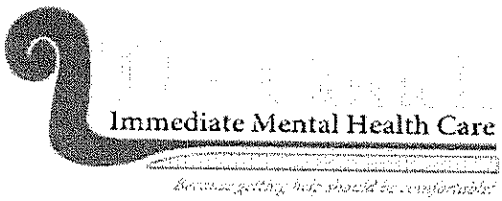

ORA FRANKEL,MD~ DANIELLE ROGERS-CANDEE,APRN-Courtney Bache, APRN
2415 LIME KILN LANE • SUITE B • LOUISVILLE, KENTUCKY 40222
(502) 414-4557 • FAX 502-873-0021

We thank you for choosing *The Couch* for your immediate and continual mental health needs. Let us know if we can assist you in any way. We strive to help you feel satisfied and fully comfortable with every aspect of your care and treatment. Here at *The Couch* ,we believe that "getting help should be comfortable".

If you do not mind, please help our business continue to grow by taking a few moments to fill out a few questions. All information that you provide is protected under HIPPA law, and will not be disclosed in any manner without your direct written consent. Thank you very much for your time. If there is anything our staff can do to help you, please do not hesitate to ask.

- The Couch Immediate Mental Health Care

If you were referred to The Couch, who told you about the office?_____

If no one referred you, how did you hear about The Couch?_____

Do you currently see a therapist or psychiatrist? ___Yes _____No

If yes, whom do you see?_____

Who is your most recent employer?_____

Would you like any of your records from today's appointment to be sent to a physician's office, therapist, or psychiatrist that you currently are a patient of? _____Yes _____NO

(If you select "YES", please include their name and contact information on the following authorization forms)

Primary Pharmacy:_____

Pharmacy Zip Code:_____

Pharmacy Phone Number: _____

AUTHORIZATION TO RELEASE PROTECTED HEALTH CARE INFORMATION

TO: THE COUCH

Pursuant to the Health Insurance Portability and Accountability Act (HIPPA) Privacy Regulation, 45 CFR §164.508, the above named healthcare provider is hereby authorized to release to _____ (Doctor, Insurance, Family member, etc.),or any of it's representatives, all medical records including but not limited to: history and physical records, admission and consent forms, office notes, orders and progress notes, discharge summaries, emergency room records, operative records, in-patient/out-patient, clinic and physical therapy records, nurses notes, consultation reports, lab reports, special diagnostic reports, films of x-rays, MRIs, CT scans or PET scans, mental health, psychiatric-non-redacted (other than psychotherapy notes which must be requested by a separate authorization),chemical dependency and HIV related records, prescription/drug records, color copies of any photographs taken, insurance, Medicare, Medicaid information, and any and all correspondence records concerning any medical treatment that (name)_____ (SSN) _____ (DOB)_____, has received from you or at your institution or which may be contained in the patient's chart. A photo static copy hereof shall be as valid as the original authorization. Each client is entitled to one free copy of his or her medical record. Additional copies will be charged $1.00 per page.

The purpose of this authorization and request is to obtain medical records pertaining to _____ (Patient name) psychiatric condition, which may be relevant for ongoing treatment planning, care, or other as designated by client. This authorization expires 6 months from the date signed. The aforementioned expiration date has not passed.

_____(Patient name) has the right to revoke this authorization in writing by providing a signed, written notice of revocation to the above-named healthcare provider and the requesting party.

The above-named healthcare provider may not condition treatment or payment on whether the above-listed patient executes the authorization. **The information disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act (HIPPA).**

Print patient name_____

Patient Signature _____
(If personal representative sign and describe his/her authority.)
Date:_____

AUTHORIZATION TO RELEASE PROTECTED HEALTH CARE INFORMATION
PSYCHOTHERAPY NOTES

TO: THE COUCH

Pursuant to the Health Insurance Portability and Accountability Act (HIPPA) Privacy Regulations, 45 CFR §164.508, the provider listed above is hereby authorized to release to _____(Doctor, Insurance, Family Member etc.), all psychotherapy notes-non-redacted which you have concerning me. A photostatic copy hereof shall be as valid as the original.

The purpose of this authorization and request ids to obtain psychotherapy notes pertaining to _____ (Patient name), which may be relevant as it pertains to ongoing treatment or as otherwise noted by client. This authorization expires 6 months from the date signed by client. The aforementioned date has not passed.

_____(Patient name) has the right to revoke this authorization in writing by providing a signed, written notice of revocation to the above-named healthcare provider.

The above-named healthcare provider may not condition treatment or payment on whether the above-listed patient executes this organization, The information disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by the privacy regulations promulgated to the Health Insurance Portability and Accountability Act (HIPPA).

_____
(Print/type patient name)

_____
(Patient Signature)
[if personal representative sign and describe his/her authority]

Social Security No.: _____

Date of Birth: _____

Date of Signature: _____

_____
(Print/type patient name—Spouse/Child)

_____
(Patient Signature)
[if personal representative sign and describe his/her authority]

Social Security No.: _____

Date of Birth: _____

Date of Signature: _____

Psychotherapy Notes

HIPPA provides special protections to certain medical records known as "psychotherapy notes". Psychotherapy notes are defined under HIPPA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group , joint, or family counseling session and that are separated from the rest of the individual's medical record,

Excluded from the definition are the following:

- Medication prescription and monitoring;
- Counseling session start and stop times;
- The modalities and frequencies of treatment furnished;
- Any summary of the following items: Diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

Psychotherapy notes, therefore, differ from "mental health records" as defined under Kentucky law. In order for a medical provider to release "psychotherapy notes" to an attorney or other third party, the patient who is the subject of the psychotherapy notes must sign a HIPPA compliant authorization to release other medical records; therefore, the patient in order for the provider to release medical records and psychotherapy notes must sign two authorization forms.

Each client is entitled to one free copy of his or her medical record. Additional copies will be charged $1.00 per page