ROBERT ROMANO, LCSW, LLC

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payers based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer, ***Robert Romano, LCSW***, at ***30 Old Kings Highway South, Darien, CT 06820***.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

ROBERT ROMANO, LCSW, LLC

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer, ***Robert Romano, LCSW***, at ***30 Old Kings Highway South, Darien, CT 06820*** or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is September 2013.

ROBERT ROMANO, LCSW, LLC

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient/Client Name:_____
DOB: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of **ROBERT ROMANO, LCSW, LLC's** notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact: **Robert Romano, LCSW** at **30 Old Kings Highway South, Darien, CT 06820; or via phone at: 203.654.9094.**

_____

Signature of Patient/Client **Date**

_____

Signature or Parent, Guardian or Personal Representative * **Date**

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

Emergency & Other Contacts

Please provide an emergency contact and, if helpful, other professionals involved in your care.

Client Information

Full name

Preferred name

Date of birth (MM/DD/YYYY)

Emergency Contact

Contact name

Relationship

Primary phone

Alternate phone

Email

Notes or Contact Preferences (Optional)

Please describe what may or may not be discussed with this person and any other contact preferences.

I authorize Robert Romano, LCSW, LLC to contact this person in an emergency or when reasonably necessary to support my safety. This authorization does not permit routine disclosure of my psychotherapy records.

I authorize contact with this person as described above.

Emergency & Other Contacts

continued

Additional Emergency Contact (Optional)

Contact name

Relationship

Primary phone

Alternate phone

Email

Notes or Contact Preferences (Optional)

Please describe what may or may not be discussed with this person and any other contact preferences.

I authorize Robert Romano, LCSW, LLC to contact this person in an emergency or when reasonably necessary to support my safety. This authorization does not permit routine disclosure of my psychotherapy records.

I authorize contact with this person as described above.

Other Professional Involved in Your Care (Optional)

Name

Role / specialty

Organization

Phone

Email

Listing a professional here does not authorize the release of records or ongoing communication. A separate written authorization may be required before information is shared.

Client name (printed)

Date

Client signature

Informed Consent for AI-Assisted & Digital Technology

My clinical practice is informed by both my experience as a psychotherapist and my background in information technology. I use carefully selected professional technology to strengthen clinical research, information synthesis, documentation, care coordination, communication, and the secure delivery of services. These tools enhance my work but do not replace the therapeutic relationship, professional judgment, or individualized care. Technology supports the quality and timeliness of my work; it never takes the place of thoughtful, attentive clinical care.

Technology Used in My Practice

OpenEvidence - A closed-source clinical AI platform for healthcare professionals that supports medical research and evidence review. I have a signed Business Associate Agreement with OpenEvidence.

ChatGPT for Clinicians - A closed-source AI service designed for clinicians that may support research, information synthesis, documentation, and clinical or administrative preparation. I have a signed Business Associate Agreement covering my use of this service.

Google Workspace - Selected services used for secure communication, document creation and storage, collaboration, and practice operations. My professional Google Workspace account is covered by a signed Business Associate Agreement for applicable HIPAA-covered services.

Zoom - Used for telehealth sessions through my HIPAA-enabled professional account, which is covered by a signed Business Associate Agreement.

Professional Responsibility

I remain responsible for reviewing information produced with technological assistance and for all clinical documentation, recommendations, and decisions. AI-generated information may contain errors or omissions and is never accepted without professional review.

AI-Assisted & Digital Technology Consent

continued

Privacy, Consent, and Your Choice

Although reasonable privacy and security safeguards are used, no electronic system can be guaranteed to be entirely free from risk. I use designated professional accounts and services covered by applicable Business Associate Agreements when protected health information is involved.

A session will never be recorded or transcribed without your explicit prior consent. Recording or transcription is not authorized by this form alone. You may decline or withdraw consent for recording, transcription, or other AI-assisted uses of your information without affecting your access to care. Any material change in how these technologies are used with your information will be discussed with you.

Your Choice

- ◯ I consent to the use of the technologies described above when relevant to my care.
- ◯ I do not consent to AI-assisted processing of information that identifies me.

Preferences, Limitations, or Exceptions (Optional)

Please describe any specific uses you are comfortable with, do not consent to, or would like to discuss.

Please ask any questions you may have before signing.

Client name (printed) Date

Client signature

Withdrawal of consent: To withdraw consent under this form, please notify the practice in writing. Withdrawal is effective when received and applies prospectively; it does not affect uses or actions already taken in reliance on your consent.

Payment Method Authorization

This form authorizes charges to a payment method provided separately. Do not write card information on this form.

Client and Payment Method Information

Client name

Date of birth (MM/DD/YYYY)

Name of payment method owner

Relationship to client

Payment Authorization

I authorize Robert Romano, LCSW, LLC to charge the payment method that I provide separately for fees I owe under the fee and cancellation policies discussed with me. This may include consultation fees, psychotherapy or coaching session fees, and applicable late-cancellation or missed-appointment charges.

The fee structure and any applicable charges will be discussed in advance. If I believe a charge is incorrect or have a billing question, I will contact the practice so the matter can be reviewed and resolved by both parties.

This authorization remains in effect until it is revoked in writing. I will notify the practice promptly if my payment information changes and will contact the practice with any questions or concerns regarding an invoice.

Good Faith Estimates

Under the federal No Surprises Act, clients who are uninsured or who do not plan to use insurance are entitled to a Good Faith Estimate of expected charges when services are scheduled or upon request. Please contact me with any questions or to request an estimate.

Payment Method Authorization

continued

Out-of-Network Benefits

I understand that Robert Romano, LCSW, LLC is an out-of-network provider with all insurance carriers. I am responsible for understanding my plan's out-of-network benefits and for payment of services regardless of whether my insurance company reimburses me.

Questions about fees, reimbursement, or out-of-network arrangements are welcome. Please contact the practice if anything is unclear or a concern arises.

For information about out-of-network reimbursement and access to the MENTAYA benefits checker, visit: https://www.robromano.com/getting-started/#benefits-checker

MENTAYA is an independent third-party service. Its results are estimates and do not guarantee coverage or reimbursement. Please confirm your benefits directly with your insurance company. Your insurance company remains the final authority on how your benefits are applied and is best positioned to explain the specific terms, coverage, exclusions, and reimbursement provisions of your policy.

Important: Do not enter a card number, expiration date, security code, bank account number, or other payment credentials on this form. Payment information must be provided separately by phone, in person, or through the designated payment processor.

Acknowledgments and Signature

☐ I authorize charges as described above.

☐ I understand that this practice is out of network, that I am responsible for all fees, and that I may contact the practice at any time with questions or concerns.

Payment method owner's name (printed)

Date (MM/DD/YYYY)

Payment method owner's signature

Revocation: To revoke this authorization, please notify the practice in writing. Revocation is effective when received, applies only to future charges, and does not affect charges already incurred or processed.

Cooper – Norcross Inventory of Preferences (C-NIP)

On each of the items below, please indicate your preferences for how a psychotherapist or counsellor should work with you by circling a number. A 3 indicates a *strong* preference in that direction, 2 indicates a *moderate* preference in that direction, 1 indicates a *slight* preference in that direction, 0 indicates no preference in either direction/an equally strong preference in both directions.

'I would like the therapist to…'

1. Focus on specific goals — No or equal preference — Not focus on specific goals

3 ☐ 2 ☐ 1 ☐ 0 ☐ -1 ☐ -2 ☐ -3 ☐

2. Give structure to the therapy — No or equal preference — Allow the therapy to be unstructured

3 ☐ 2 ☐ 1 ☐ 0 ☐ -1 ☐ -2 ☐ -3 ☐

3. Teach me skills to deal with my problems — No or equal preference — Not teach me skills to deal with my problems

3 ☐ 2 ☐ 1 ☐ 0 ☐ -1 ☐ -2 ☐ -3 ☐

4. Give me 'homework' to do — No or equal preference — Not give me 'homework' to do

3 ☐ 2 ☐ 1 ☐ 0 ☐ -1 ☐ -2 ☐ -3 ☐

5. Allow me to take a lead in therapy — No or equal preference — Take a lead in therapy

-3 ☐ -2 ☐ -1 ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐

Scale 1. If score is 8 to 15 then strong preference for therapist directiveness. If score is -2 to 7 then no strong preference. If score is -3 to -15 then strong preference for client directiveness.

6. Encourage me to go into difficult emotions — No or equal preference — Not encourage me to go into difficult emotions

3 ☐ 2 ☐ 1 ☐ 0 ☐ -1 ☐ -2 ☐ -3 ☐

7. Talk with me about the therapy relationship — No or equal preference — Not talk with me about the therapy relationship

3 ☐ 2 ☐ 1 ☐ 0 ☐ -1 ☐ -2 ☐ -3 ☐

8. Focus on the relationship between us — No or equal preference — Not focus on the relationship between us

3 ☐ 2 ☐ 1 ☐ 0 ☐ -1 ☐ -2 ☐ -3 ☐

9. Encourage me to express strong feelings — No or equal preference — Not encourage me to express strong feelings

3 ☐ 2 ☐ 1 ☐ 0 ☐ -1 ☐ -2 ☐ -3 ☐

10. Focus mainly on my thoughts — No or equal preference — Focus mainly on my feelings

-3 ☐ -2 ☐ -1 ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐

Scale 2. If score is 7 to 15 then strong preference for emotional intensity. If score is 0 to 6 then no strong preference. If score is -15 to -1 then strong preference for emotional reserve

11. Focus on my life in the past — No or equal preference — Focus on my life in the present

3 ☐ 2 ☐ 1 ☐ 0 ☐ -1 ☐ -2 ☐ -3 ☐

12. Help me reflect on my childhood — No or equal preference — Help me reflect on my adulthood

3 ☐ 2 ☐ 1 ☐ 0 ☐ -1 ☐ -2 ☐ -3 ☐

13. Focus on my future — No or equal preference — Focus on my past

-3 ☐ -2 ☐ -1 ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐

Scale 3. If score is 3 to 9 then strong preference for past orientation. If score is -2 to 2 then no strong preference. If score is -3 to -9 then strong preference for present orientation.

14. Be challenging — No or equal preference — Be gentle

-3 ☐ -2 ☐ -1 ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐

15. Be supportive — No or equal preference — Be confrontational

3 ☐ 2 ☐ 1 ☐ 0 ☐ -1 ☐ -2 ☐ -3 ☐

16. Not interrupt me — No or equal preference — Interrupt me and keep me focused

3 ☐ 2 ☐ 1 ☐ 0 ☐ -1 ☐ -2 ☐ -3 ☐

17. Be challenging of my own beliefs and views — No or equal preference — Not be challenging of my own beliefs and views

-3 ☐ -2 ☐ -1 ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐

18. Support my behaviour unconditionally — No or equal preference — Challenge my behaviour if they think it's wrong

3 ☐ 2 ☐ 1 ☐ 0 ☐ -1 ☐ -2 ☐ -3 ☐

Scale 4. If score is 4 to 15 then strong preference for warm support, If score is -3 to 3 then no strong preference. If score is -4 to -15 then strong preference for focused challenge.

Additional client preferences for exploration and consideration (as appropriate to service provision)

Do you have a *strong* preference for:

- A therapist of a particular **gender**, **race/ethnicity**, **sexual orientation**, **religion**, or **other personal characteristic**?
- A therapist/counsellor who speaks a **specific language** that is most comfortable for you?
- **Modality** of therapy: such as individual, couple, family, or group therapy?
- **Orientation** of therapy: such as psychodynamic, cognitive, person-centred, or other?
- **Number** of therapy sessions: such as four, dependent on review, open-ended, or other?
- **Length** of therapy sessions: such as 50 mins, 60 mins, 90 mins or other?
- **Frequency** of therapy: such as twice weekly, weekly, monthly, ad hoc or other?
- **Medication**, psychotherapy, or both in combination?
- Use of **self-help** books, self-help groups, or computer programs in addition to therapy?
- **Any other** strong preferences that come to mind? (and do raise them at any point in therapy)
- What would you most **dislike** or **despise** happening in your therapy or counselling?

Authorization for Use or Disclosure of Protected Health Information

Client Information

Client Last Name_____ First Name _____MI ___
DOB:___/___/____
Client Address
_____
Client Home Phone: _____ Cell/Work Phone:
_____
Client Email Address: _____

Recipient Information

I, _____, do hereby authorize _____ to release a copy of my mental health information to the person or facility below.

Name of person/facility to receive medical information: _____
Phone: _____
Address: _____

Date of Authorization: ___/___/_____
Authorization to expire on ___/___/_____ or upon the happening of the following event: _____
_____

Information to be Released (*Note: Requests for release of psychotherapy notes cannot be combined with any other type of request.*)

□ My entire mental health record

□ Only those portions pertaining to: _____
(Specific provider name and/or dates of treatment)

□ Authorization for Psychotherapy Notes ONLY (Important: If this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected health information.)

□ Other: _____

Purpose of Information Release:

□ Further mental health care
□ Applying for insurance
□ At the request of the individual
□ Payment of insurance claim
□ Vocational rehab, evaluation
□ Other (specify): _____
□ Legal investigation
□ Disability determination

Authorization and Signature

I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

_____ _____

Signature Date

If signed by a personal representative:

(a) Print your name: _____

(b) Indicate your relationship to the client and/or reason and legal authority for signing:

Patient is: □ minor □ incompetent □ disabled □ deceased

Legal authority: □ parent □ legal guardian □ representative of deceased

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 they 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.

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 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.

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.