Authorization for Use of Electronic Medical Record

Patient Name: _________________________ Date of Birth: ________________

I, ______________________________________, understand that as a client of Art of Therapy Center, my client record will be included as part of an electronic medical record (EMR) utilized by Art of Therapy Center.

I understand that my client record is considered protected health information by Art of Therapy Center and shall be protected pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy and Security Rules. I understand that all psychotherapy notes will be included in the electronic medical record. I understand that my signature does not authorize Art of Therapy Center to release my client information to any party outside of Art of Therapy Center without my expressed approval.

I understand that the electronic medical record utilized by Art of Therapy Center is a computerized method of retaining, organizing, and maintaining my client record instead of the use of paper charts.

I hereby authorize Art of Therapy Center to maintain my client record within the Art of Therapy Center medical record system (Theranest).

________________________ ______________

Signature of Client/Guardian Date

________________________ ______________

Signature of Witness and Title Date