2578 Broadway #607
New York, NY 10025
talkspace.com

Authorization to Discuss Protected Health Information

Patient Name	**Date of Birth**	**Patient Talkspace Email Address**
Patient Address		

I authorized Providers and Employees of Talkspace to disclose the Protected Health Information described below to the selected recipient(s).

I understand that:

1. I have the right to revoke this authorization, in writing, at any time.
2. I understand that revocation will not be effective to the extent that any person or entity has already acted in reliance on my authorization.
3. The information disclosed is protected by law and may not be redisclosed by covered entities without my written authorization or as otherwise authorized by law. However, if the person or entity who receives this information is not subject to these laws then this information can be redisclosed without my authorization.
4. I have a right to receive a copy of this signed authorization.
5. My refusal to sign this authorization will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits.

☐ Healthcare Provider	☐ Insurance Company or Designee	☐ Attorney	☐ Court
☐ Law Enforcement	☐ Employer	☐ Other (*Please specify*) ____________	

Name of Recipient(s): ____________________

Name of Organization: ____________________

Address: ____________________

Fax #: ____________ Email: ____________ Phone #: ____________

Section A: Purpose of Disclosure (why the information is needed)			
☐ Patient Request	☐ Benefits Application	☐ Legal	☐ Employment
☐ Treatment	☐ Other (*Please specify*)		

Section B: Description of the Information to be Released (what type of information to be released)

1. Check the box(es) below that apply to the specific personal health information you want disclosed:
   - ☐ Limited Information from Counseling Services (go to questions 2 and 3)
   - ☐ Limited Information from Psychiatric Services (go to questions 2 and 3)

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☐ Entire Counseling Services Medical Record, including diagnostic assessments, treatment plans, progress notes, treatment summary, dates of services (go to question 3)

☐ Entire Psychiatric Services Medical Record, including diagnostic assessments, medication history, treatment plans, progress notes, treatment summary, dates of services (go to question 3)

2. Complete only if you selected “Limited Information”. Check all that apply:

☐ Diagnostic Assessments	☐ Treatment plans	☐ Progress notes	☐ Treatment Summary
☐ Dates of Services	☐ Psychiatric Evaluation	☐ Other (*Please specify)*	

Include: (*indicate by Initialing*)

_______ Alcohol/Drug Treatment

_______ HIV-Related Information

3. Check only one box below indicating how long Talkspace can use this authorization to disclose your personal health information (subject to applicable law)
   ☐ Disclose my personal health information in its entirety
   ☐ Disclose my personal health information for a specified period only
   beginning (mm/dd/yyyy) and ending (mm/dd/yyyy)

4. This authorization shall be in effect until ______________.[1]

Signature of Patient or Representative *(wet or electronically time-stamped only)*		**Date**
Printed name of Representative (if applicable)	**Relationship to the Patient (if applicable)**	**Signature of Minor (if applicable)**

[1] ***If no date is provided, the authorization will expire one year from the date of signature below.***