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

Authorization for Release of Protected Health Information

Patient Name	Date of Birth	Patient Talkspace Email Address
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form.

I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except chat history which is considered psychotherapy notes, and CONFIDENTIAL HIV RELATED INFORMATION only if I place my initials on the appropriate line in Item 6. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 6, I specifically authorize release of such information to the person (s) indicated in Item 5.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE INDIVIDUAL(S) SPECIFIED IN ITEM 5.

5. **Name and address of person(s) to whom this information will be sent**:

(*insert name and address of recipient*) _____

_____

☐ Paper Copy Delivery
☐ Fax Copy Delivery: (*insert fax number*) _____
☐ Electronically Delivery: (*insert email address*)_____
☐ Copy of Health Information to be paper copy delivered to same patient name and address as above.
☐ Copy of Health Information to be electronically delivered to same patient name and email address as above.

6. **Specific information to be released**:
☐ Counseling Services Medical Record from (*insert date*) _____ to (*insert date*) _____
☐ Counseling Services Medical Record from (*insert date*) _____ to Present (*date of signature)*

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☐ Entire Counseling Services Medical Record, including diagnostic assessments, treatment plans, progress notes, treatment summary, dates of services
☐ Psychiatric Services Medical Record from (*insert date*) _____ to (*insert date*) _____
☐ Psychiatric Services Medical Record from (*insert date*) _____ to Present (*date of signature*)
☐ Entire Psychiatric Medical Record, including psychiatric evaluation, treatment plans, progress notes, medication history, treatment summary, dates of services
☐ Other: _____

_____

Include: (*indicate by Initialing*)

_____ Alcohol/Drug Treatment

_____ HIV-Related Information

7. **Reason for release of information**: ☑ At request of patient ☐ Other: _____	8. **Date on which this authorization will expire**:[1]
9. If not the patient, name of person signing form:	10. **Authority to sign on behalf of patient**:

_____ _____

Patient Name | Patient Signature *(wet or electronically time-stamped only)* | Date

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