Talkspace

Office address
622 3rd Ave, 10th Floor
New York, NY 10017

Mailing address
PO Box 659
Portsmouth, NH 03802

Third Party Authorization for Release of Protected Health Information

Talkspace Member Name	Talkspace Member Date of Birth	Talkspace Member Email Address
Talkspace Member 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, except 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 DISCLOSE MY HEALTH INFORMATION WITH ANYONE OTHER THAN THE INDIVIDUAL SPECIFIED IN ITEM 5.

5. **Third Party Name and address to whom this information will be sent**:

Recipient name: _____

Recipient mailing address: _____

_____

☐ Paper Copy Delivery to above mailing address

☐ Electronic Delivery to Recipient Email Address: _____

☐ Fax Copy Delivery: _____

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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)*

☐ 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 "Yes" by Initialing*)

_____ Alcohol/Drug Treatment

_____ HIV-Related Information

7. **Reason for release of information**:

☐ At request of member

☐ Other: _____

8. **Date on which this authorization will expire**:[1]

_____

9. **If not the member, Name of person signing form**:

_____

10. **Authority to sign on behalf of member**:

_____

_____ _____

Member Name *(Print)* Member Signature and Date *(wet or electronically time-stamped only)*

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