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

Third Party Authorization for Release of Confidential Information

Privacy Act Information
The purpose of this form is to provide the individual member the means to make a written request for a copy of their protected health information (PHI) maintained by Talkspace under the federal Health Insurance Portability and Accountability Act (HIPAA) and its Privacy Rule. The disclosure of the information requested on this form is voluntary; however, if information needed to locate records for release is not furnished completely and accurately, Talkspace will be unable to comply with the request. Failure to furnish the information will not have any effect on any other benefits to which the individual may be entitled. We may accept or, in permitted cases, deny the request. We will inform you of any denials and any rights the individual may have to request a review. We may request additional information or take other reasonable steps to verify your identity before disclosing PHI to you.

Section A. Member Information: (individual whose information will be released)

I, _____ (PRINT: First and Last Name), Date of Birth:_____/_____/_____
with Talkspace account email address (PRINT): _____ authorize, Providers and Employees of Talkspace to disclose the Protected Health Information described below to the following recipient:

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

Name of Recipient: _____
Name of Organization: _____
Address: _____
Fax #: _____ Email: _____ Phone #: _____

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

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

Records from <u>Alcohol and Drug Treatment</u> Program**

☐ Diagnostic Assessment	☐ Individualized Treatment Plan(s)	☐ Progress Notes	☐ Treatment Summary
☐ Dates of Services			
☐ Other (*Please specify)*			

** The enclosed information is protected by Federal confidentiality rules (42 CFR Part 2 & 45 CFR Part 160 & 164). The Federal rules and state law prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is otherwise permitted by Federal and state law. A

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general authorization for the release of medical or other information is not sufficient for this purpose. 42 CFR Part 2 restricts any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

Records from Counseling Services

☐ Diagnostic Assessments	☐ Individualized Treatment Plan(s)	☐ Progress Notes	☐ Treatment Summary
☐ Dates of Services			
☐ Other			

Records from Psychiatric Services

☐ Psychiatric Evaluations	☐ Individualized Treatment Plan(s)	☐ Progress Notes	☐ Treatment Summary
☐ Dates of Services	☐ Medication History		
☐ Other			

Time Period and Restrictions (select all that apply)

☐ From: ____/_____/_____ To: _____/_____/_____ ; OR
☐ From: ____/_____/_____ To: Present

Specific information that may NOT be disclosed (*Please specify*):

Expiration

This authorization shall be in effect until **_____/_____/_____.**

If no date is provided, the authorization will expire one year from the date of signature below. I understand that I have the right to revoke this authorization, in writing at any time. I understand that revocation will not be effective to the extent that any person or entity has already acted in reliance on my authorization.

I understand that:

- 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.
- This authorization may be revoked at any time through verbal or written notification, except to the extent that action has been taken in reliance on it.
- I have a right to receive a copy of this signed authorization.
- My refusal to sign this authorization will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits.

	/ /
Signature of Patient or Representative	**Date**

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Printed name of Representative (if applicable)	**Relationship to the Patient (if applicable)**	**Signature of Minor (if applicable)**

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Instructions - Authorization for Release of Confidential Information

Instructions - Authorization for Disclosure of Health Information
This form is used for you or your Personal Representative to authorize Talkspace to release your protected health information to another person or organization in accordance with Health Insurance Portability and Accountability Act (HIPAA) and its Privacy Rule.
"Protected Health Information," means individually identifiable health information. It is information about you, including your name, address and medical information and may relate to your past, present or future physical or mental health or condition.
Section A. Member Information: (individual whose information will be released)
Print your complete name, birth date, and Talkspace account email address
Section B: Purpose of Disclosure (why the information is needed)
Provide a brief description of the reason you want this information released. This will allow us to assist you in ensuring that you receive the information you require.
Section C: Description of the Information to be Released (what type of information will be released)
• ***Dates of Service***: the date or range of dates of mental health service contact between a health service provider and a member/client. • ***Diagnostic Assessment***: a clinical evaluation provided by a licensed professional designed to gather information on the member's initial problem, current mental status and the diagnostic impression. • ***Individualized Treatment Plan(s):*** a treatment plan for each type of service provided (e.g., psychiatric services, counseling). • ***Medication History***: a detailed account of all prescribed medications. • ***Progress Notes***: includes details of the member's symptoms, assessment, diagnosis, and treatment. • ***Psychiatric Assessment:*** a clinical evaluation that assesses an individual mental, social and psychological functionality. • ***Treatment Summary***: a detailed summary of a member's concerns, the type of treatment received, and any side effects or other problems caused by treatment.

Note: Chat history is available to members within the platform and is not considered a part of the legal medical record.