Talkspace

INDIVIDUAL 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 if I do not place my initials on the appropriate line in Item 5. 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 5, I specifically do not authorize release of such information to the person (s) indicated in Item 4.

2. 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.

3. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCLOSE MY HEALTH INFORMATION WITH ANYONE OTHER THAN THE INDIVIDUAL SPECIFIED IN ITEM 5.

4. **Talkspace Member Name and address to whom this information will be sent**:

Self/Talkspace Member name: _____

Self/Talkspace Member mailing address: _____

_____

☐ Electronic Delivery to Member email address: _____

☐ Copy of Health Information to be paper copy delivered to same member name and address as above.

☐ Copy of Health Information to be electronically delivered to same member name and email address as above.

5. **Specific Information to be released**:

☐ Counseling Services Medical Record from (*insert date*) _____ (*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

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

☐ Other _____
_____

I understand that the medical record documentation requested above may contain sensitive information, including, but not limited to HIV or AIDS, the treatment of alcohol or drug abuse, and reproductive health. I authorize the release of such information unless otherwise noted below:

Do Not Include: (*indicate "**No**" by Initialing*)

_____ Alcohol/Drug Treatment
_____ HIV-Related Information
_____ Reproductive Health

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

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

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

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

Mailing address
PO Box 659
Portsmouth, NH 03802