
***Authorization for Disclosure of Protected Health Information &***
***Request for Confidential Communication***

I, _____ _____ hereby authorize
(First and Last Name) (DOB)

Trade Winds Therapy, LLC and Relationship Coaching and _____
(Contact Person)

_____
(Address City State Zip Code Phone Number)

To release the following information: (Check all that apply)

☐ Summary of Progress ☐ Evaluation/Assessment ☐ Service Plans
☐ Termination Summary ☐ Attendance/Participation/Progress
☐ Other: _____

For the purpose of:

☐ Ongoing Treatment ☐ Medical Care ☐ Payment ☐ Coordination of Care ☐ Legal issues
☐ Other: _____

Periods of treatment:

☐ All Treatment Episodes ☐ Current Treatment Episode ☐ Specific Treatment Episode:
Begin Date: _____ End Date: _____

If the purpose of this disclosure is marked as "Other" whether or not Treatment, Payment or Operations are checked, then this is a HIPAA Complaint Authorization and Trade Winds Therapy, LLC and Relationship Coaching must provide me a copy.

I understand that my records or those of the individual listed above are protected under state and federal mental health confidentially regulations including 42CFR Part 2. Information cannot be disclosed without my written consent, unless otherwise specifically provided for in the regulations. I understand and agree that this release form may be sent to the agencies and persons identified above. Copies of this form may be used in lieu of the original.

I understand there is potential for information disclosed as a result of this release/authorization to be re-disclosed by the recipient and therefore no longer protected by the HIPAA Privacy regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken based upon it. This consent expires and cannot be used past the indicated date or event.

Expiration Date: _____
(Not more than one year)

I consent to releasing Trade Winds Therapy, LLC and Relationship Coaching and all related parties from any liability resulting from the release of this information.

X _____ _____
CLIENT/GUARDIAN SIGNATURE DATE

X _____ _____
THERAPIST/WITNESS SIGNATURE DATE

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Consent Revoked: _____ _____
CLIENT SIGNATURE DATE