Talkspace

AUTHORIZATION TO VERBALLY DISCLOSE PROTECTED HEALTH INFORMATION

Talkspace Member Name:	Talkspace Member Date of Birth:	Talkspace Member Email Address:
Talkspace Member Address:		

I authorized Providers and Employees of Talkspace to verbally disclose the Protected Health Information described below to the selected recipient(s).

I understand that:

1. I have the right to revoke this authorization, in writing, at any time.
2. I understand that revocation will not be effective to the extent that any person or entity has already acted in reliance on my authorization.
3. 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.
4. I have a right to receive a copy of this signed authorization.
5. My refusal to sign this authorization will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits.

Section A: Third Party Information (whom the information is to be verbally disclosed with)			
☐ Healthcare Provider	☐ Insurance Company or Designee	☒ Attorney	☐ Court
☐ Law Enforcement	☐ Employer	☐ Other (*Please specify*) _____	

Name of Recipient(s): Vicoria Richmond

Name of Organization: Records Deposition Service

Address: P.O. Box 5054, Southfield, MI 48086-5054

Fax #: (248) 357-3337 Email: requests@recdep.com Telephone No. (248) 357-3330

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)

1. Check the box(es) below that apply to the specific personal health information you want disclosed:
   ☐ Limited Information from Counseling Services (go to questions 2 and 3)
   ☐ Limited Information from Psychiatric Services (go to questions 2 and 3)

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☐ Entire Counseling Services Medical Record, including diagnostic assessments, treatment plans, progress notes, treatment summary, dates of services (go to question 3)

☐ Entire Psychiatric Services Medical Record, including diagnostic assessments, medication history, treatment plans, progress notes, treatment summary, dates of services (go to question 3)

2. Complete only if you selected "Limited Information". Check all that apply:

☐ Diagnostic Assessments	☐ Treatment plans	☐ Progress notes	☐ Treatment Summary
☐ Dates of Services	☐ Psychiatric Evaluation	☐ Other (*Please specify)*	

I understand that the verbal disclosure of the requested information 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 verbal disclosure of such information unless otherwise noted below:

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

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

3. Check only one box below indicating how long Talkspace can use this authorization to disclose your personal health information (subject to applicable law)
   ☐ Disclose my personal health information in its entirety
   ☐ Disclose my personal health information for a specified period only
   beginning (mm/dd/yyyy) and ending (mm/dd/yyyy)

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

Signature of Patient or Representative *(wet or electronically time-stamped only)*		**Date**
Printed name of Representative (if applicable)	**Relationship to the Patient (if applicable)**	**Signature of Minor (if applicable)**

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

March 2026

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

Mailing address
PO Box 659
Portsmouth, NH 03802