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CONFIDENTIAL RELEASE FORM HIPAA Authorization for Release of Protected Health Information (PHI) ***This form complies with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (45 CFR §164.508).***

1. Individual Information
Client Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

2. Person or Entity Authorized to Release Information

I authorize the following individual or organization to release my protected health information:

Name of Person: _____

_____

Address: _____

Phone: _____ **Email:** _____

3. Person or Entity Authorized to Receive Information

I authorize the disclosure of my protected health information to:
Name of Individual/Organization: Special Learning 1-ON-1 LLC
Address: 1122 East Main Suite 4 Bozeman MT 59715
Phone: 406-580-2640 Email: speciallearning1on1@gmail.com

4. Description of Information to Be Released
(Check any that apply or specify)
☐ Treatment records / clinical notes
☐ Assessments / evaluations
☐ Diagnosis and treatment plans
☐ Progress notes
☐ Other (specify): _____
Date range of information: From _____ to _____

5. Purpose of Disclosure
☐ Continuity of care
☐ Personal use
☐ Legal
☐ Other (specify): _____

6. Sensitive Information (Initial if applicable)
I understand that the following information may be included if applicable. Please initial to authorize:
☐ __ Mental health records (excluding psychotherapy notes unless specifically authorized)
☐ __ Substance use disorder treatment records (42 CFR Part 2)

7. Method of Disclosure
☐ Email
☐ Mail
☐ In-person pickup
☐ Fax ☐ Other: _____

8. Expiration of Authorization
This authorization will expire on (date or event): _____
If no date/event is specified, this authorization will not expire **unless revoked.**

9. Right to Revoke
☐ I understand that I may revoke this authorization at any time by submitting a written request to the releasing provider, except to the extent that action has already been taken in reliance on this authorization.

10. Redisclosure Notice
☐ I understand that information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA, unless otherwise protected by law.

11. Voluntary Authorization
☐ I understand that signing this authorization is voluntary and that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

12. Signature
By signing below, I acknowledge that I have read and understand this authorization.
Signature of Patient/Client or Legal Representative: _____
Printed Name: _____
Relationship (if not patient/client): _____
Date: _____

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