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

Phone Number

Address

2. PERSON OR ENTITY AUTHORIZED TO RELEASE INFORMATION

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

Name of Person / Organization

Address

Phone

Email

3. PERSON OR ENTITY AUTHORIZED TO RECEIVE INFORMATION

I authorize the disclosure of my protected health information to:

Special Learning 1-on-1 LLC
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:

- ☐ Treatment records / clinical notes
- ☐ Assessments / evaluations
- ☐ Diagnosis and treatment plans
- ☐ Progress notes
- ☐ Other (specify):

Date range of information — From

To

HIPAA Release of Information

5. PURPOSE OF DISCLOSURE

☐ Continuity of care ☐ Personal use ☐ Legal

☐ Other (specify):

6. SENSITIVE INFORMATION

The following may be included if applicable. Please initial to authorize:

Initial

Mental health records (excluding psychotherapy notes unless specifically authorized)

Initial

Substance use disorder treatment records (42 CFR Part 2)

7. METHOD OF DISCLOSURE

☐ Email ☐ Mail ☐ In-person pickup ☐ Fax

Other (specify)

8. EXPIRATION OF AUTHORIZATION

This authorization will expire on (date or event) — if left blank, it will not expire unless revoked

9. ADDITIONAL TERMS

Right to Revoke: I may revoke this authorization at any time by submitting a written request to the releasing provider, except to the extent action has already been taken in reliance on it. Redisclosure: 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. Voluntary: signing this authorization is voluntary and will not affect my treatment, payment, enrollment, or eligibility for benefits.

10. 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