## Release of Information Consent – ThriveLine

* *indicates a required field*

ThriveLine: Telepsychiatry & Mental Wellness, PLLC
Phone: (888) 351-2623 | Fax: (207) 209-4142
Email: katrinahockey@thrivelinetelepsychiatry.com
Secure Messaging: https://spruce.care/thriveline

**Patient Information**
* Patient's Name: _____
* Patient's Date of Birth: _____

*** I authorize ThriveLine: Telepsychiatry & Mental Wellness PLLC to:**
☐ Send
☐ Receive
☐ Send and Receive

*** The following information:**
☐ Medical history and evaluation(s)
☐ Mental health evaluations
☐ Developmental and/or social history
☐ Educational records
☐ Progress notes, and treatment or closing summary
☐ Substance Use Related Records
☐ Psychiatric Notes (Initial Evaluations, Follow ups, Treatment Plans, Medications, Diagnoses, Assessments)
☐ Other: _____
☐ ALL RECORDS (ALL OF THE ABOVE)

*** Name of the practice or individual with whom you authorize me to exchange mental health records and/or coordinate care:**
Name: _____
* Address: _____
* Phone: _____
* Fax: _____
Email: _____

*** Your relationship to client:**

☐ Self
☐ Parent/legal guardian
☐ Personal representative
☐ Other: _____

* **The above information will be used for the following purposes:**
☐ Planning appropriate treatment or program
☐ Continuing appropriate treatment or program
☐ Determining eligibility for benefits or program
☐ Case review
☐ Updating files
☐ Care Coordination
☐ ALL OF THE ABOVE
☐ Other: _____

**Patient Rights and Important Information:**
I understand that this information may be protected by:
• Title 45 (Code of Federal Regulations, Parts 160 and 164 – HIPAA Privacy Rules)
• Title 42 (Confidentiality of Substance Use Disorder Patient Records, Part 2)
• Applicable state laws

**I understand that:**
• The recipient may not be subject to these laws if they are not a covered health care provider.
• This authorization is voluntary and may be revoked in writing at any time.
• Unless otherwise specified, this authorization automatically expires 1 year from the date of signature.
• I have been informed what information will be shared, the purpose, and who will receive it.
• I may refuse to sign this authorization without it affecting my ability to receive care (unless required for certain services).
• If I am a legal guardian or court-appointed representative, I must attach documentation of my authority.
• If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

* Signature: _____
I consent to sharing information provided here.
* Date: _____
Witness Signature (if client is unable to sign): _____
Witness Date: _____