Blue Couch Therapy
SPEAK YOUR MIND & FIND PEACE
954-993-1646
hello@BlueCouchTherapy.co
BlueCouchTherapy.co

Exhibit E

Release of Information/Medical Record (ROI)

Please complete all sections of this authorization form. If any sections are left blank this form will be invalid and we will not be able to process your request to release your medical record.

I, **Client**'s LAST name _____ Client's FIRST name _____ Client's DOB _____/_____/_____

Client's email address _____ Client's phone number (_____)_____-_____ authorize Blue Couch Therapy to share the information listed on this form with the recipient identified below by the following mechanism (make a selection):
(__) Email (__) Fax (__) Verbal (this is chosen when a member wants to authorize their clinician to have verbal conversations regarding their care).

Authorization	**Purpose of the Disclosure**
I authorize to disclose/release the following (check all that apply) electronically	Reason(s) the information is being released. Examples:
○ Biopsychosocial Assessment	○ Continuity of care
○ Treatment plan/treatment review	○ Legal proceedings
○ Treatment summary	○ Insurance reimbursement
○ Discharge summary	○ Personal use- "At the request of the individual."

To the **recipient** listed below (person/business whom the requested records will go to):

Recipient's Full Name _____ Relationship to the client _____

Recipient's address _____
City state zip code

Recipient's phone number (_____)_____-_____ Recipient's fax number (_____)_____-_____

Recipient's email address _____

- I understand that this authorization to release information will remain in effect for 1 year from the date listed or until this set date _____/_____/_____ or until I revoke it in writing to hello@BlueCouchTherapy.co, except when the information has already been disclosed based on the original authorization. Signing the ROI is not required to receive treatment unless the release is for certain purposes (e.g., research or insurance eligibility).
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.
- I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment from Blue Couch Therapy, except where disclosure of the information is necessary for my treatment.
- I understand that I can request a copy of this form after I sign it.
- I acknowledge that Blue Couch Therapy is not responsible for improper disclosure of records resulting from any misinformation I may have provided while completing this form.

By printing my name and date below, I electronically sign this release and acknowledge the above and below statements. Or by printing and placing a wet signature on this form and returning it.

_____ _____ _____
Client Printed name Client Signature Date

_____ _____ _____
Witness/Representative Printed name Witness/Representative Signature Date