This form allows Specthrive Wellness & Behavioral Health LLC to communicate with the people, schools, or providers you list below.

It is used in both coaching and therapy work. Please complete every section, then sign and date at the bottom.

You can submit this form electronically (by typing your signature) or print it and sign by hand. Both methods have the same legal effect.

Client Information

Child's full name

Date of birth

Today's date

Parent or guardian name(s)

Provider

Nancy Nyabuti, MA, LPCC. Outpatient Mental Health Therapist at Specthrive Wellness & Behavioral Health LLC.

What You Are Authorizing

I authorize Specthrive Wellness & Behavioral Health LLC to:

- Share information about the client named above with the parties listed in this form.
- Obtain information about the client named above from the parties listed in this form.

Parties Authorized for Release

List up to three people, schools, or organizations. If you need more space, use the notes area at the bottom of this section.

Party 1: Name

Party 1: Role or organization

Party 1: Phone or email

Party 2: Name

Party 2: Role or organization

Party 2: Phone or email

Party 3: Name

Party 3: Role or organization

Party 3: Phone or email

Additional parties or notes (optional)

Information to Share

Check all that apply.

- [ ] Educational information (IEP, 504, school performance)
- [ ] Behavioral observations
- [ ] General support recommendations
- [ ] Coordination of services
- [ ] Other (specify below)

If 'Other' is checked, please describe

Purpose of Disclosure

Check all that apply.

- [ ] Coordination of care or support
- [ ] School planning and accommodations
- [ ] IEP or 504 support
- [ ] General support for client functioning
- [ ] Other (specify below)

If 'Other' is checked, please describe

Method of Communication

Check all that apply.

- [ ] Phone
- [ ] Email
- [ ] Written reports

Expiration of This Authorization

This authorization will expire on whichever date you select below. If neither is selected, the authorization defaults to one year from the signature date.

- [ ] One year from the signature date
- [ ] Specific expiration date (enter below)

Specific expiration date

Your Rights

Voluntary signing: This authorization is voluntary. Coaching and therapy services are not conditioned on signing, except where specific coordination clearly requires release of information.

Right to revoke: You may revoke this authorization at any time by submitting a written request to me. Revocation will not apply to information that was already shared based on this authorization before the revocation was received.

Limits of confidentiality: Once information is shared with a third party, it may no longer be protected by HIPAA or other privacy laws.

Sign and Submit

Sign this authorization by typing your name, your email, your relationship to the child, today's date, and checking the agreement box below. Under the federal ESIGN Act and Minnesota's Uniform Electronic Transactions Act (UETA), your typed name has the same legal effect as a handwritten signature when provided with the intent to sign. To sign on paper instead, print this form and complete the same fields by hand.

Your full name (typed signature)

Your email

Relationship to child

Date

- [ ] I am providing my electronic signature on this form. By checking this box and clicking Submit, I agree my typed name above has the same legal effect as a handwritten signature, I authorize the disclosures described in this form, I intend to be bound by the terms of this document, and I have had the opportunity to print this document for my records.