RELEASE OF INFORMATION AUTHORIZATION

I understand that a fundamental part of the collaborative process is fully disclosing matters relevant to the issues. I hereby authorize the collaborative professionals, meaning my Coach, the Child Development Specialist, and the Financial Neutral to discuss any matters they learn from me with each other, and my attorney.
This may include protected health information ("PHI") as described below. I understand that this authorization is voluntary. I understand that if the person authorized to receive the information is not a health plan or health care provider, the released PHI may no longer be protected by federal privacy regulations (HIPAA).

Client name: _____ Date: _____

Persons *providing/receiving/requesting* information:

Collaborative Attorney for Client: _____
Collaborative Attorney for Spouse: _____
Collaborative Coach for Client: _____
Collaborative Coach for Spouse: _____
Collaborative Child Specialist: _____
Collaborative Financial Neutral:
_____

Purpose of use or disclosure: ***To assist in resolution through the collaborative process***.

The Client must read and initial the following statements:

1. I understand that this authorization will expire on when the divorce is final. Initials: _____

2. I understand that I may revoke this authorization as described in the Notice of Privacy Practices at any time by notifying the my coach and my coach, attorney, child specialist and/or the financial neutral in writing, but if I do it will not have any affect on any actions they took in reliance on my authorization before they received the revocation. I understand that failure to allow disclosure of information significant to the collaborative process may cause the collaboration to end. Initials: _____

FURTHER, THE PHI AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NON-COMMUNICABLE DISEASE, OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT ARE NOT LIMTIED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA AND THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). I FURTHER UNDERSTAND THAT MY PHI MAY INDICATE THAT I HAVE BEEN TREATED FOR PSYCHOLOGICAL OR PSYCHAITRIC CONDITIONS.

This agreement is entered into between the collaborative professional and the client to make clear their respective understandings of their roles and responsibilities during this process.

_____ _____
Signature of client Date

_____ _____
Signature of collaborative professional Date