HIPAA AUTHORIZATION FORM
FOR THE USE OF THERAPIST AID INTERACTIVE TOOLS

Provider's name:	
Provider's address:	
Provider's email address:	
Client's name:	

_____ ("**Your Provider**") has partnered with Therapist Aid LLC ("**Therapist Aid**") to provide you with access to Therapist Aid's interactive tools. By signing this Therapist Aid HIPAA Authorization Form (the "**Authorization**"):

You, _____, hereby authorize Your Provider to use and/or disclose the following protected health information ("**PHI**") about you to Therapist Aid to provide you with the access to Therapist Aid's interactive tools:

- The content and pages you access through Therapist Aid's interactive tools, which may include information related to healthcare; and
- Internet or electronic network activity information.

Therapist Aid is not a health care provider or health plan, or a business associate of a health care provider or health plan covered by federal healthcare privacy regulations. As a result, the PHI described above will no longer be protected by federal healthcare privacy regulations (such as the Health Insurance Portability and Accountability Act, or "**HIPAA**") and may be subject to redisclosure, but Therapist Aid implements reasonable security measures designed to keep your PHI private, such as industry-standard encryption of data in transit, employee training, and access controls. By providing this Authorization, you agree to Therapist Aid's handling of your information, including the PHI described above, in accordance with the privacy policy published by Therapist Aid.

You may refuse to sign this Authorization. Your refusal to sign (a) will not affect your ability to receive other treatments Your Provider provides but (b) will limit your access to Therapist Aid's interactive tools because Therapist Aid cannot provide such tools without Your Provider's disclosure of your PHI.

This Authorization will remain in effect during your course of treatment with Your Provider using Therapist Aid. Neither Your Provider nor Therapist Aid will receive any payments in exchange for disclosing the PHI described above under this Authorization, and your information will not be disclosed for marketing purposes.

You have the right to revoke this Authorization, in writing, at any time, except to the extent that Your Provider has acted in reliance upon it, by sending written notification via one of the methods identified below. Your revocation will not apply to disclosures made by Your Provider pursuant to this Authorization prior to the date Your Provider receives your written request to revoke your Authorization.

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Provider's Mailing Address:_____

Provider's Email Address: _____

If you are an authorized representative of a patient (such as a parent or legal guardian of a patient who is a minor) and providing this Authorization on behalf of the patient, by signing your name below, you declare that you have the legal authority to provide this Authorization on behalf of _____.

_____ _____

Client's Name or Name of Authorized Representative | Date of Signature

_____ _____

Client's Signature or Signature of Authorized Representative | Authorized Representative's Relationship to Client