Cheryl Harris Sharman, MA, CSD, TITC-CT
Email: cheryl@alisteningspace.com (best way to reach me) (secure, HIPAA-Compliant)
Phone: 646-397-1141 (secure, HIPAA-Compliant Google Voice #)
Addresses: Mailing: P.O.Box 38662, Baltimore, MD 21231; **Office:** 2526 St Paul St, Baltimore, MD 21218

Trauma Work
Authorization for Release or Exchange of Information

This form authorizes me to Release or Exchange Information to/with other individual providers regarding your trauma work (e.g., current therapist, previous therapist, traumatologist(s), health care providers).

Your First and Last Name(s): _____ Your Date of Birth: _____

(1.) I authorize Cheryl Harris Sharman, MA, CSD, TITC-CT to Release or Exchange Information to:

Other Provider's Name: _____
(Note: I need one form for each Provider with whom you authorize me to Release or Exchange Information.)

Other Provider's Phone Number: _____ Other Provider's Address: _____

Other Provider's Email Address: _____
(Note: By providing their email address, you are authorizing me to send them emails regarding your trauma work. I will always copy you on such emails. But do *not* provide this if you do not want me to communicate with them by email. Please review my *HIPAA Email Consent Form* for more info re: emails.)

(2). A few reminders from my *HIPAA Notice of Privacy, Video, and Telephone Practices*, which you signed:

- You may **request anyone you wish to attend a session with you**. Keep in mind, however, that lessens your privacy.
- Effective 01/18/21, to be HIPAA-Compliant, I will keep two sets of **records**:
  - on every client: longer, detailed, private, *process notes*: for my own *process* (see below for more info)
  - on Trauma work clients: brief *progress notes* (that we had a session, what assessments or interventions and general topics we discussed); for HIPAA Compliance, these form part of **your Designated Record Set** (as outlined by U.S. HHS 45 CFR § 164.524; see https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/index.html
- **I will *not* disclose my private, *process notes* on you; to you, or to anyone**.
  - If I make private, *process notes* on you, for my own use, those remain private to me. I will not share them with you, or anyone. The law protects them separately.

(3.) Type of Information to be Released or Exchanged: (Please Check)

☐ Verbal (in joint, or conjoint, phone or video session(s) with you, the above provider, and me)
☐ Written (see above: this will *not* include my private, *process* notes on you, but could include emails)

(4.) Purpose of the Release or Exchange of Information: ☐ Coordination of Care ☐ Other: _____

(5.) I understand that once this authorization is completed and submitted, it cannot be altered in any way. If you wish to alter it, this authorization must be revoked, and a new authorization completed. It may be revoked at any time. In writing. Otherwise, this release remains valid until you are no longer a client or until a named Expiration Date of: _____ (please write N/A if you do not wish to give an Expiration Date)

(6.) I also understand that my information may not be protected from re-disclosure by the requester/recipient of the information; however, if this information is protected from the Health Insurance Portability and Accountability Act of 1996 ('HIPAA'), the recipient may not re-disclose such information without my further written authorization to that recipient unless otherwise provided for by state or federal law.

Name of Client (print): _____ Signature: _____ Date: _____

Please complete, sign, date, save this (as a PDF), and return (by email or mail). THANK YOU.