Minded.

122 Grand Street
NY, NY 10013
Phone: 909-442-0618
Fax: 909-442-5639

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby request that health information regarding my care and treatment at Minded Inc. be released as set forth in this form in accordance with New York State Law and Privacy Rule of the Health Information Portability and Accountability Act of 1996 (HIPAA). I authorize and waive any liability or legal responsibility of the employees, staff, or agents of Minded Inc., to RELEASE information from the medical record(s) of:

PATIENT NAME: David Abraham
PATIENT HOME ADDRESS: 914 Luder St, La Marque TX 77568
DATE OF BIRTH: 11/10/1990
PHONE #:

Release the following information (Check all the apply):

- [x] Complete Medical Record from Minded, Inc.
- [ ] Medical Record from Minded, Inc. from _____ to _____
- [ ] Medical History, Evaluation Records
- [ ] Hospital Records including reports
- [ ] Consultation Documentation
- [ ] Diagnostic Tests (Labs, X-rays, etc.)
- [ ] Prescription Data
- [ ] Summary of Record
- [ ] Mental Health
- [ ] Drug/Alcohol Treatment
- [ ] HIV
- [ ] Other (please specify):

It is my understanding that the information to be used or disclosed will be used for the following purposes (check all that apply):

- [ ] At the request of the individual signing this authorization (no purpose need be specified)
- [ ] Additional medical care
- [x] Change of Provider
- [ ] Insurance Eligibility/Benefits
- [ ] Legal Investigation or Action
- [ ] Other (Specify):

If the requested portion of the medical record contains information pertaining to Psychiatry, Alcohol or Drug Treatment or contains HIV related information, you must specifically consent to the release of such information by initialing one or both of the following:

_____I understand that if my records contain information concerning psychiatry, drug, and alcohol treatment, such information will be released pursuant to this consent. This authorization is protected by Title 42 of the Code of Federal Regulations. According to Title 42 any person who received information from the record of such a patient may not show this information to anyone else without my written permission.

_____I understand that if my records contain confidential HIV related information, such information will be released pursuant to this consent form **and will require an additional authorization** (NYS DOH-2557) which is required for disclosure when my medical records contain information relating to Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV) including but not limited to results and the fact that the test was taking.

This consent will automatically expire one (1) year from the date of my signature or the date contained here _____ which is less than one year from my signature.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present any written revocation to Minded Inc. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I AM REQUESTING MEDICAL INFORMATION BE SENT TO THE INDIVIDUAL/ORGANIZATION LISTED BELOW:

_____

_____

_____

_____I specifically authorize that any sensitive information regarding HIV/AIDS, substance abuse (alcohol or drug abuse) and/or mental health, may be used by or disclosed to the above reference recipients.

_____I **do not** authorize the release of HIV/AIDS, substance abuse and/or mental health information

Patient Signature: _____

Date: 10/18/2022