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:

David Abraham
davidabraham333@gmail.com

_____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