RELEASE AUTHORIZATION
INCLUDING THE RELEASE OF PROTECTED HEALTH INFORMATION

Introduction: This authorization allows Attention MD to discuss your confidential mental health information with someone other than you. This could be:

- a person such as a parent, relative or designated representative
- an individual health care provider: physician, therapist, counselor
- a clinic, medical practice
- an insurance company
- a school or educational organization.

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Authorization: My signature below authorizes Attention MD (Dr. Mason or his staff) to release the information or documentation described below to the following and allows them to share information with Attention MD as well.

1. Subject of information (individual whose information is to be disclosed):

   Patient Name _____ Date of birth_____

2. Person(s) or organization(s) sharing information with Attention MD:
   ***** We will need a <u>Fax number</u> if sending/receiving records with another doctor or organization.***

   Name: _____
   Phone: _____ Fax: _____
   Expiration: ☐ One year ☐ When I revoke ☐ On specific date _____

   Name: _____
   Phone: _____ Fax: _____
   Expiration: ☐ One year ☐ When I revoke ☐ On specific date _____

   Name: _____
   Phone: _____ Fax: _____
   Expiration: ☐ One year ☐ When I revoke ☐ On specific date _____

3. Documents/ information to be released (check all that apply):

   ☐ All records including mental health, substance use, HIV/AIDS

   ☐ All records except (please specify) _____

   ☐ Other (please specify) _____

********SIGNATURE NEEDED ON BACK*******

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As described in our Notice of Privacy Practices, health care providers generally may not release information or documents containing the individually identifiable health information of a patient or dependent to persons not involved with treatment or payment of health benefits, unless the patient or adult dependent signs an Authorization for Release of such information. For example, Attention MD will generally not share protected health information of a patient with his or her spouse absent an authorization.

Such authorization must identify who you are authorizing to receive information and describe the information you intend to be disclosed. Your authorization has a life of one year unless you indicate that the permission is perpetual. After one year, you must complete a new authorization if you want additional information to be disclosed following the expiration of restricted permissions.

I understand that the terms of this authorization are governed by the Health Insurance Portability and Accountability ACT of 1996, and its implementing regulations ("HIPPA"). I understand that I have the right to revoke this authorization, at any time prior to Attention MD's compliance with the request set forth herein, provided that the revocation is in writing. I understand that any revocation must include my name, address, telephone number, date of this authorization and my signature and that I should send it to:

ATTENTION MD
Dr. Oren Mason
2213 Wealthy SE Suite 230
Grand Rapids, MI 49506
Fax: 877-411-1871
omason@attention.md

_____
Signature of Individual

OR

_____ _____
Signature of Personal Representative Description of Personal Representative's authority

AND

_____
Date of Authorization