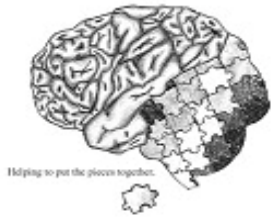

NORTHERN
MICHIGAN PSYCHIATRIC SERVICES, P.C.

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RELEASE OF INFORMATION AUTHORIZATION

Patient Name: _____ Date of Birth: _____

I, the undersigned patient/parent/legal guardian, hereby authorize Northern Michigan Psychiatric Services, P.C. and any of its agents to obtain and release medical record information concerning the treatment of the above named patient.

"**Telehealth**" is defined as the use of electronic information and telecommunication technologies to support or promote long-distance clinical health care, patient and professional health-related education, public health, or health administration. Telehealth may include, but is not limited to, telemedicine. A "telehealth service" means a health care service that is provided through telehealth. Note, the technology/modality definition of "telehealth" is broader than that of "telemedicine" (the latter requiring real-time, interactive audio or video, or both).

"**Telemedicine**" is defined as the use of an electronic media to link patients with health care professionals in different locations. The health care professional must be able to examine the patient via a real-time, interactive audio or video, or both, telecommunications system and the patient must be able to interact with the off-site health care professional at the time the services are provided.

I understand that Northern Michigan Psychiatric Services is using Telehealth/Telemedicine as a form for patients to communicate with their providers. I consent to this format and my questions have been answered to my satisfaction.

I understand that such information cannot be disclosed without my written informed consent unless otherwise provided by law. I further understand information to be disclosed may include treatment of psychiatric, substance abuse, and HIV/AIDS related illnesses. I agree the information may be faxed for expediency. I have the right to revoke this authorization, in writing, at any time by sending such written notification to the above address. I understand that a revocation is not effective to the extent this office has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand I have the right to inspect or obtain a copy of the health information, and may refuse to sign this authorization. If not specifically revoked in writing, this consent remains in effect until the patient turns 18. I understand and consent for the medical record of the patient listed above to be copied and sent to and received from the organizations as indicated above.
Further release of information disclosed by the above authorization is prohibited by the Michigan Mental Health Code (Public Act 258of 1974 as amended, Section 758.759.750). The released information may not be copied, shared, or re-released, except as consistent with the authorized purpose stated above. This authorization is in compliance with Title 42 of the Code of Federal Regulations Part II which also prohibits disclosure.
I have also had to the opportunity to have this form explained to me and have my questions answered.

_____

Parent/Legal Guardian Signature (Circle One Please) Date

Confidential information: any further release of this document without additional authorization by the patient will be a breach of confidentiality. Federal Regulation (2 CFP, Part 2) and State Laws (P.A. 258. Chapter 7. Section 748 in Parentheses) DDK 10/02.1/03.5/03.