Authorization for Release of Information

I, ________________________________, give my permission to Sasha Strong
(Your name)

to release/obtain information in the form of written records

with/to/from: ____
(Name of psychiatrist or medical group)

about this patient:____
(Your name)

I understand that this information will be used only for the purpose(s) of: an attestation of suitability to participate in a qualitative study on how people use mindfulness and Buddhist psychology and philosophy to recover from bipolar disorder, which includes verification of having met criteria for a diagnosis of bipolar disorder in the past. I give my permission for my provider to transmit this information using Box, a HIPPAA-compliant secure file transfer service that provides free personal accounts, or via postal mail.

The authorization will be in effect from ______________ until ______________, or if no date is specified, for one year from today's date unless otherwise rescinded.

I understand that I give my permission for the records and/or information to be obtained from or released to only the person or organization, and for the purpose listed above, and only for the time shown above. I understand that this release will only be used in connection with my participation in a qualitative research study entitled "How people use mindfulness meditation and Buddhist philosophy and psychology to recover from bipolar disorder."

Authorization: I certify that this request has been made voluntarily. I understand that I may revoke this authorization at any time, except to the extent that action has been taken to comply with it. I hereby release any service provider or individual from any liability, which may result from furnishing the information requested as authorized in this release. Redisclosure of my medical records may not be accomplished without further written consent.

A COPY OF THIS AUTHORIZATION IS TO BE CONSIDERED AS VALID AS THE ORIGINAL.

Participant/Patient name: ____

Participant/Patient Signature: ____ Date: ____________

Provider/Witness name: ____

Provider/Witness Signature: ____ Date: ____________

Please submit this completed form to your medical provider. Provider, please use the HIPPAA-compliant secure upload link at http://www.brilliancyresearch.com/uploads/ . Alternatively, fax it to 971 999-0678 or mail it to Brilliancy Research, Attn: Sasha Strong, 4531 SE Belmont St, Suite 316, Portland OR, 97215. Please contact researcher Sasha Strong at sasha@brilliancyresearch.com or 971-279-7261 if you have any questions.