

Authorization to Release Information

Melissa Miller, PsyD

I authorize my psychologist, Dr. Melissa Miller, to release:

Information Records Other: Specify _____

This information should only be released to:

Name:

Organization:

Phone number:

Fax:

I am requesting that Dr. Miller release this information for the following reasons (if you are my patient and do not desire to state a specific purpose, simply write "at the request of the individual"):

This authorization shall remain in effect until (a particular date) or until (a specific event, such as formal termination of therapy):

I have the right to revoke this authorization, in writing, at any time by sending such written verification to Dr. Miller's office. However, this revocation will not be effective to the extent that Dr. Miller has already taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that Dr. Miller generally may not condition psychological services up on my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Signature of Patient

Date

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.