Schelle Miller, Ph.D., Licensed Psychologist
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CONSENT TO USE OR DISCLOSE HEALTH INFORMATION

I authorize SCHELLE MILLER, Ph. D., Licensed Psychologist

(Check one or both boxes): ☐ *to use and disclose* and/or ☐ *to obtain* the following specific health and medical information **to/from**:

_____
(Name of person, their title, and organization the information is being released to and/or obtained from)

_____
(Address of Person/Organization the information is to be released to and/or obtained from)

_____ _____
(Fax Number of Person/Organization the information is to be released to and/or obtained from)

(Telephone Number of Person/Organization the information is to be released to and/or obtained from)

for: _____ _____
(Patient's Name) (Patient's DOB)

Specific medical information to be released consisting of (Check those that apply):

☐ Summary of treatment and treatment recommendations ☐ Diagnosis ☐ Psychological Evaluation(s)
☐ Other Evaluations (specify): _____ ☐ Referral and Insurance Information
☐ Educational test results, grade reports, school reports of behavior/emotional functioning ☐ Individual Education Plan (I.E.P
☐ Alcohol/Substance Abuse Evaluations and Treatment ☐ Other (specify): _____

For the specific purpose(s) of (Check those that apply):

☐ Facilitating assessment or treatment ☐ Assisting in educational planning
☐ Other (list other purposes): _____

This authorization will expire (must choose one)

☐ 12 months from the date signed below ☐ Other: (insert Date or Event): _____

If SCHELLE MILLER, Ph. D, Licensed Psychologist. is requesting this Authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

1) We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
2) You may inspect a copy of the protected health information to be used or disclosed;
3) You may refuse to sign this Authorization; and
4) We must provide you with a copy of the signed authorization.

I understand that the records requested may be protected under 42 C.F. R. Part 2, governing Alcohol Drug Abuse Patient Records and State Confidentiality Laws and regulations and cannot be released without my consent unless otherwise provided for by regulation. State and Federal Law regulations prohibit any further disclosure of such records without my specific written consent or except when otherwise permitted by such regulation.

I also understand that I may revoke this consent in writing at any time unless action has already been taken upon it, and that in any event the consent expires in twelve months from the signing or upon conditions as described above.

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE.

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization. Unless revoked earlier or otherwise indicated, this Authorization will expire 12 months or shall remain in effect for the period reasonably needed to complete the request. You may review SCHELLE MILLER, Ph. D, Licensed Psychologist *Notice of Privacy Practices* for additional information about the uses and disclosures of information described in this Consent prior to signing this Consent. ***I understand that I have the right to revoke this Consent provided that I do so in writing, except to the extent that*** SCHELLE MILLER, Ph. D, Licensed Psychologist ***has already used or disclosed the information in reliance on this Consent.***

Name of Client (please print): _____

Signature of Client: _____ **Date:** _____

_____ **Relationship to Client:** _____ **Date:** _____
Name & Signature of Parent/Legal Guardian/Legal Representative (If applicable).

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