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Dr. Amy D. Miller & Associates, Ltd.

CONSENT TO RELEASE INFORMATION

I, _____ _____
(Name of Patient) (Date of Birth)

Authorize _____

To release the following information from my medical/psychiatric records:

_____Discharge Summary
_____Psychiatric Evaluation
_____Medical History & Physical
_____Social Assessment
_____Vision Screening
_____Educational Reports
_____Progress Notes
_____Other (Specify)_____

_____Psychological/Neuropsychological Testing
_____Consultations
_____X-Rays
_____Lab Reports
_____EEG/EKG
_____Verbal communication
_____ Written communication
_____Audiogram

To be sent to: _____

_____

For the purpose of: _____

Information released is not to be further disclosed or used for any other purpose than that stated in this authorization. It is understood that I have the right to revoke this consent in writing at any time. Any revocation shall be in writing, signed by me and the signature witnessed by a person who can attest to my identity. No written revocations of consent shall be effective until it is received by the person otherwise authorized to disclose records and shall have no effect on disclosures made prior therto. I understand that I have the right to inspect and copy the information released. I further understand that my refusal to consent to the release of information to the facility or person named herein for the states purpose will not in any way impede service given to me.

This authorization is valid until: _____
(Calendar Date)

*_____ Date _____
(Patient's Signature – if over age 13)

*_____ Date _____
(Parent/Guardian's Signature – Relationship)

*_____ Date _____
(Witness' Signature)

*Signature Required: Adult patient (18 or over) and witness: Parent (or guardian) and child plus witness, if child is age 12 through 17; Parent (or guardian) and witness, if child under 12 or patient adjudicated incompetent.