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AUTHORIZATION & RELEASE FORM

This form, when completed and signed by you, authorizes David B. Miller, Psy.D.,P.A. to release & receive protected information from your clinical record to the person you designate. I authorize my psychologist, David B. Miller, Psy.D., and/or his administrator to release pertinent information. This information should only be released to:

Name: ____
Address: ____
Telephone: ____

As Dr. Miller's patient you do not have to state the specific purpose for this request-it is simply a request by you as an individual with clinical information in this office

I authorize ______________________ to release pertinent information from my clinical record to **David B. Miller, Psy.D., P.A.**

This authorization shall remain in effect until treatment is completed. You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have 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 my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. Additionally, I understand that there are/may be limits on confidentiality despite best efforts to protect privacy, including forms of electronic transmission i.e. doxyme, email, or text message communications. I understand that my medical record may not be used for forensic legal purposes; that my treatment is intended for emotional well being, healing and personal growth.

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 HIPPA Privacy Rule.

Patient Name (print) ___________________ Date______________________
Patient or Representative Signature______________________________________
Relationship to Patient____