Dr. Michele Durrance-Miller, Psy.D.
Licensed Psychologist

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I am completing this form to allow the use and sharing of protected health information about

Printed name:_____ Date of Birth: _____

I authorize this person or organization _____
to use or disclose the following information:

_____ Psychological or psychiatric evaluation(s), reports, assessments, treatment notes, summaries, or other documents with diagnoses, prognoses, recommendations, or testing records, and behavioral observations or checklists completed by any staff member or the client, or similar documents

_____ Academic and educational records, including achievement and other test results, reports of teachers' observations, and all other school or special education documents.

_____ Other _____

To this person or organization _____

The information will be used/disclosed for the following purposes: _____

I understand and agree that this Authorization will be valid and in effect until _____

I understand that after that date or event, no more of this information can be used or released to the person or organization unless I sign a new Authorization like this one.

I understand that I can revoke or cancel this authorization at any time. If I do this, it will prevent any disclosures after the date it is received but can not change the fact that some information may have been sent or shared before that date.

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the professional or facility listed above.

I understand that I may inspect and have a copy of the health information described in this authorization. There may be a cost for this copy or other services.

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations.

I affirm that everything in this form that was not clear to me has been explained and I believe I now understand all of it.

_____ _____
Signature of client or his or her personal representative Date

_____ _____
Printed name of client or personal representative Relationship to the client

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