Carol J. Miller, Ph.D.
Clinical Psychologist

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AUTHORIZATION

I authorize my/my child's psychologist, **Carol J. Miller, Ph.D.,** and

_____

_____

to exchange information about myself/my child _____

regarding _____

_____

I am requesting the release of this information for the following reasons:_____

_____

This authorization shall remain in effect until _____

I understand that I have the right to revoke this authorization in writing at any time by mailing such written notification to the above address. However, my revocation will not be effective to the extent that action has been taken in reliance on the authorization or if the 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/my child's psychologist generally may not condition psychological services upon my signing an authorization, unless the psychological services are provided for the information of creating health information for a third party.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and no longer protected by the HIPAA Privacy Rule.

_____ _____

Signature of Patient or Patient's Legal Representative

Date