Kathryn B. Miller, PhD
Licensed Psychologist

Authorization For the Release of Clinical Information

Name:_____
Date of birth:_____

I authorize Kathryn B. Miller, Ph.D., L.P. to: ☐ disclose to ☐ obtain from ☐ exchange with

_____
(Person or organization with whom information will be exchanged)

_____
(Address, phone number, fax)

The information will be used for:
☐ Treatment planning ☐ Coordination/continuity of care ☐ "At the request of the individual"

- ☐ Summary of history / diagnostic interview
- ☐ Discharge summary and diagnosis
- ☐ Reports of psychological testing
- ☐ Other (specify): _____
- ☐ Clinical impressions and observations
- ☐ Personal observations
- ☐ Psychotherapy notes

This authorization shall remain in effect until (fill in expiration date) or until (fill in an event that relates to the individual or the purpose of the use or disclosure).

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address or by signing below. 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 Dr. Miller 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.

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 HIPAA Privacy Rule.

Signature of Patient_____ Date _____

_____ Date _____
(Signature of Parent / Legal Guardian if Patient is under 18 years of age)

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.
Sign / date here to revoke this authorization: _____ Date _____

5101 Olson Memorial Hwy, Suite 4004, Golden Valley, MN 55422 T: 763.595.7294 ext. 114 F: 763.595.7293