



# 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          | ____ Psychological/Neuropsychological Testing |
| ____ Psychiatric Evaluation     | ____ Consultations                            |
| ____ Medical History & Physical | ____ X-Rays                                   |
| ____ Social Assessment          | ____ Lab Reports                              |
| ____ Vision Screening           | ____ EEG/EKG                                  |
| ____ Educational Reports        | ____ Verbal communication                     |
| ____ Progress Notes             | ____ Written communication                    |
| ____ Other (Specify) _____      | ____ 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 thereto. 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.