AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION (V. P/SA)

David E. Miller, Ph.D., Inc.
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Phone: (614) 863-4125 Fax: (614) 863-4040

Patient Name: ______________________________ Date of Birth: ________________

I authorize David E. Miller, Ph.D., Psychologist to receive and/or share the following specified protected health information with the following, either in written or verbal form, to more appropriately provide psychological treatment to me or my family:

Facility and/or Provider:

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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. I further understand that such information would be used solely in my treatment and not further disclosed to other parties.

Specific Information Requested: (please circle preprinted items and clearly specify descriptions of items written in blank space):

Diagnostic/Intake Evaluation **Consultative Report(s)** **Summary of Treatment** **Psychological Report(s)**

Observations & Recommendations **Clinical Impressions** **Treatment Plans/Requests for Additional Services**

Results of Physical Examination **Blood Test/Lab Results** **Psychiatric Consultation** **Current Prescribed Medications**

Other:____

The purpose of this request is: *("At the Request of Patient" is all that is required if you are my patient and you do not desire to state a specific purpose):*

At the Request of Patient **Ongoing or Continuity Treatment Services** **Consultation w/clinician**

Psychological Assessment **Consideration of Possible Medication for Patient**

Other: ____

This authorization shall remain in effect until ____________ (date) or until ______________________ (12 months or until the end of treatment).

I hereby authorize the use or disclosure of my protected health information as specified above. This authorization permits disclosure of information about mental illness or substance abuse conditions, as well as other health conditions and information. I understand that this authorization is voluntary and that I may refuse to sign it. I understand that I may revoke this authorization at any time by giving written notification to my provider or any member of the office staff. A revocation will not affect any action taken in reliance on the authorization prior to the revocation nor if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. Other limitations on my right to revoke this authorization may be found in my provider's Notice of Privacy Practices.

I understand that treatment may not be denied if I refuse to sign this authorization, except: (1) If the authorization is the very reason for seeking the health care (e.g., a pre-employment physical), that health care may be denied; or (2) If the authorization is for disclosure to a research study, I may be denied the treatment that is part of the study. In addition, the following consequences might occur if I refuse to sign this authorization: (1) If the authorization is to demonstrate to a health plan that a service should be paid for, the health plan may refuse to pay for it; and (2) If the authorization is sought by an insurer because I am seeking enrollment or eligibility, the insurer may deny me the coverage I am seeking. I understand that a health plan may not refuse payment or benefits if I refuse to authorize disclosure of certain psychotherapy notes.

______________________________ ______________

Signature of Patient or Personal Representative Date

(If authorization is signed by a personal representative of the patient, a description and/or proof of representative's authority to act for the patient must be provided)

Relationship of Personal Representative to the Patient: ______________________________

Witness: ______________________________ Date: __________