AUTHORIZATION TO RELEASE INFORMATION

_____, born on _____,
(Full Name; please print) (Month/Date/Year)

requests and authorizes:

_____,

who is employed by Debbie Miller, LLC, to disclose/obtain information related to my case, including the results of examinations and evaluations, as well as diagnosis and treatment, to/from the following:

Name: _____

Title: _____

Agency: _____

Address: _____

City: _____ State: _____

Zip Code: _____

Phone: _____ Fax: _____

Email: _____

I am aware that all information I hereby authorize to be obtained from this person or agency will be held strictly confidential within the limits of the law and cannot be released by the recipient without my written consent.

I understand that unless otherwise limited by state or federal laws and regulations, and except to the extent that action has to be taken on my consent, I may withdraw this consent in writing at any time.

Signed: _____ Date: _____

Parent/Guardian: _____ Date: _____

Witnessed: _____ Date: _____