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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I HEREBY AUTHORIZE KENNETH J. MILLER, M.D. TO RELEASE ALL INFORMATION IN MY MEDICAL RECORDS, INCLUDING DIAGNOSIS, TREATMENT INFORMATION, BUSINESS AND OTHER NOTATIONS TO:

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Name of Person / Organization

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Address

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Phone Number

THE PURPOSE OF THIS RELEASE OF INFORMATION IS FOR: (*circle one*)
CONTINUITY OF CARE, TREATMENT, ASSESSMENT/EVALUATION REPORT, OR OTHER (*please specify*): ____

THIS AUTHORIZATION IS VALID FOR THE PERIOD ________________(*months/years*)

THIS AUTHORIZATION IS SUBJECT TO REVOCATION BY THE PATIENT AT ANY TIME BY PROVIDING WRITTEN NOTICE.

____ ____________________
Signature of Patient *Date*

____
Printed Name of Patient

____ ____________________
Signature of Parent/Legal Guardian (if patient is under 18) *Date*