Miller Therapy, LLC
Speech and Language Pathology, Orofacial Myology

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Miller Therapy, LLC
IL License # 146.009014

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AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

Section A: <u>Client complete for all authorizations. Please check and initial statement(s) that applies.</u>

[ ] I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is **voluntary**. I understand that if the organization authorized to **receive** the information is not a health plan or a health care provider, that organization may also disclose my health information. If this happens, I understand that my information may no longer be protected by federal privacy regulations. Initials: _____

[ ] I hereby authorize Miller Therapy, LLC to obtain individually identifiable health information as described below. I understand that this authorization is **voluntary**. Information obtained will be for the sole use of Miller Therapy, LLC to provide treatment, receive payment or for health care operations purposes. Initials: _____

Client Name: _____ **Date of Birth:** _____

Miller Therapy, LLC may release to or obtain from as indicated below (physician(s), healthcare providers, educational program(s), or other agencies) my health information.

_____
Name, Address, Phone, Fax

_____
Name, Address, Phone, Fax

_____
Name, Address, Phone, Fax

Description of information to be disclosed or obtained:
[ ] Evaluation/Assessment [ ] Progress Notes/Summary [ ] Medical History [ ] Discharge Reports [ ] Psychological Reports
[ ] IEP/School Records [ ] Medical Consultation [ ] Physical/Immunization Records [ ] Other as here specified
_____

Client or the Client's representative read and initial the following statements:

1. I understand that this authorization will expire within one year from today's date. Initials: _____
2. I understand that I may revoke this authorization at any time by notifying Miller Therapy, LLC in writing. But, if I do revoke this authorization, my revocation will not have an effect on any actions Miller Therapy, LLC took in reliance upon my authorization before it received my revocation. Initials: _____

You may revoke this authorization by making a written request of Revocation of Authorization. Please address your Request for Revocation of Authorization to: Miller Therapy, LLC, 331 S. Forrest Ave., Arlington Heights, IL 60004, Attn: Kristin Miller

3. Miller Therapy, LLC will not condition your treatment or payment for your health care services on your completing and signing this authorization.

_____
Miller Therapy, LLC personnel to complete for requests to obtain information:
1. The purpose of the use or disclosure is: [ ] Program Planning [ ] Other_____
2. Miller Therapy, LLC _ will **X will not** receive direct or indirect compensation in exchange for using or disclosing the information listed above.

NOTICE TO CLIENT: You or your representative may inspect and/or copy the health information in accordance with Miller Therapy, LLC's policies.

_____
Section B: <u>Must be completed by client or client representative for all authorizations.</u>

_____ _____
Signature of Client or Client's Representative **Date**

_____ _____
Representative Name *(Please Print)* **Relationship to Client**