Authorization To Release Protected Information

Name: ____

Date of Birth: ______/______/______ Phone#: (_____) ______ - _________

Address: ________________________ City: ________________ State: ________ Zip: ___________

I hereby authorize Georgemiller, Whyte & Associates, PC to (Check all that apply)

☐ RELEASE TO ☐ RECEIVE FROM ☐ EXCHANGE WITH

Name: ____

Address: ________________________ City: ________________ State: _______ Zip: __________

Phone: (______) ______ - _________ Fax: (______) ______ - __________

Specify information to be released ____________________________________

Purpose for disclosure ____________________________________

This authorization is valid until: _____/_____/_____

Any protected health information may not be further disclosed except pursuant to my authorization.

I understand that I have the right to copy and inspect the information being disclosed. I have the right to revoke this authorization, in writing, at any time by sending such written notification to Georgemiller, Whyte & Associates, PC. However, revocation will not effect any action taken in reliance on this authorization before receiving written notice of revocation. If I refuse to sign this authorization, my protected health information will not be released.

I understand that generally psychological services are not conditional upon my signing an authorization. However, it has been explained to me that if I refuse to consent to this Release of Information, the following are the consequences (or indicate "none")

____

X____________________________________ (Recipient age 12 or over) **Date:** ______/______/______

X____________________________________ (Parent/Guardian) **Date:** _____/______/______

X ____________________________________ (Print name) ________________________ (Relationship to recipient)

X____________________________________ **Date:** _____/______/______
(Witness)

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