C · P · S
Child Psych Services, LLC

AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient (printed): ____

Date of Birth (mm/dd/yyyy): _____/_____/___________

I hereby authorize Julie Miller, Psy.D., ABPP to disclose information about the above-named patient's psychological testing results and/or psychological treatment services to the person or facility named below. This information may include any psychological evaluation report.

The information is to be released or reviewed by phone, in person, by mail, fax, or secure electronic transmission to:

Name of Person or Facility: ____

Street Address: ____

City, State, Zip Code: ____

Phone:_________________________________ Fax:_________________________________

Email: ____

I understand this request/authorization for release of records between Dr. Julie Miller and the above-named person or facility. I understand that this authorization will remain in effect for six (6) months after the date signed below by the patient/parent/guardian for the above-named patient. I understand that I have the right to revoke this authorization at any time by submitting a request in writing to Dr. Julie Miller.

I hereby state that I have read and fully understand the above statements as they apply to me. I hereby consent to the disclosure of the treatment records to the purpose and extent stated above.

____ ___________________

Signature of Patient or Parent if Minor Date