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# AUTHORIZATION TO RELEASE INFORMATION

I, (name of patient) _____ (date of birth) _____, (hereinafter "Patient") hereby authorize Dr. Sandra Miller (hereinafter "Provider") to disclose health treatment information and records obtained in the course of treatment of the abovementioned Patient, to:

_____

_____

_____

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider at 181 Fourteenth Street; Suite 450; Atlanta, GA 30309 to be effective.

This disclosure of information and records authorized by Patient is required for the following purpose:

a) continuity of care_____
b) communication with Patient's other healthcare provider_____
c) personal records _____

Such disclosure shall be limited to the following specific types of information:

a) Neuropsychological evaluation
b) Treatment Summary
c) Other_____

Patient understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule.

This authorization shall remain valid until: _____

Patient's signature: _____ Date:_____

Guardian's signature (if applicable): _____ Date: _____

Guardian's relationship: _____