The MINDset Center
Authorization Form for Susan Miller, M.A., C.A.S.

This form, when completed and signed by me, _____ (parent/guardian name), authorizes the release of protected health/educational information (PHI) from the clinical record of _____ (client's name) to the person(s) I designate. I authorize my provider, Susan Miller, to release:

_____

_____
(provide specific and detailed description of the information requested for disclosure).

This information should only be released to:

Name: _____ Agency: _____

Address: _____

Telephone: _____

I am requesting that Mrs. Miller release this information for the following reasons:

_____
("at the request of the individual" is all that is required).

This authorization shall remain in effect until: _____
(fill in expiration date or event that relates to the individual or the purpose of the use or disclosure. Note: date may not exceed one year).

I understand that Mrs. Miller cannot re-disclose information she received from another health care provider if that health care provider requested that the information not be re-disclosed. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

I have the right to revoke this authorization at any time by sending written notification to Mrs. Miller. However, my revocation will not be effective to the extent that she has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my provider generally may not condition assessment services upon my signing an authorization unless the assessment services are provided to me for the purpose of creating health information for a third party.

_____ _____
Signature of parent or legal guardian Date

Relationship to client: _____

Susan Miller
_____
Electronic Signature of witness (provider)