**MILLER COUNSELING SERVICES**
**NICHOLAS MILLER, LPC.**
**Office Address: 168 Rogers St. Suite 103 Blairsville GA 30512**
**PH. 770-500-0681 FAX 844-876-6931**
**EMAIL: miller_counseling@yahoo.com**
**www.nmillercounselingservices.com**

## Authorization for Release of Protected Health Information

Client Name:_____ Date of Birth:_____/_____/_____
**I authorize:**
**____ Nicholas Miller, Ed.S., LAPC____ Sheena Rymer, LMSW. _____ Lamar Barber, LPC**

____ Exchange ____ Release ____ Obtain

**The following information:** Only that information checked below will be included in this release of information:
____ Intake, Diagnosis & Treatment ____ Brief Summary of Assessment & Treatment
____ Discharge Summary ____ Other (Specify)_____

**To/With/From:**
Name:_____ Phone: _____-_____-_____
Facility: _____ Fax: _____-_____-_____
Address: _____

**This information is requested for the purpose of:**
____ Continuity of Care ____ Other: _____

This authorization shall remain in effect for the duration of treatment unless an expiration date is specified.

You have the right to revoke his authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have 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 counselor generally may not condition counseling services upon my signing an authorization unless the counseling services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____
**Signature of Client** **Date**

_____ _____
**Signature of Parent or Guardian (If appropriate)** **Date**