

Client Name: _____

Date of Birth: _____

Karen D. Miles, MD, PLLC
Authorization for Release of Information

I, the below signed, hereby authorize Karen D. Miles, MD, PLLC (which includes all providers in the practice) to release information to _____, and in turn I authorize the named persons/agency above to release information to Karen D. Miles, MD, PLLC. I understand that the purpose on this information is for consistency in care and treatment and shall include only that of the nature and to the extent specified below.

Please initial beside each category authorized.

- _____ Copies of medical and/or psychiatric treatment history
- _____ Family/Social History
- _____ Medical History
- _____ Current and Previous medications
- _____ Legal history
- _____ Substance use/abuse documentation
- _____ Documentation regarding HIV, AIDS, sexually transmitted diseases
- _____ Other _____

I understand the contents to be released, the need for the information, and that there are state and federal regulations protecting the confidentiality of authorized information. I also understand that this information cannot be released without by written consent and hereby acknowledge that this consent is truly voluntary and is valid for one year or upon the following specified date _____ (not to exceed one year from date of signature). I acknowledge that services are not contingent upon this release, or revocation of this release. I further acknowledge that I may revoke this consent at any time in writing except to the extent that action has been taken in reliance on the authorization.

I understand that law prohibits re-disclosure of any information disclosed to the recipient pursuant this authorization by a plan or provider covered by HIPAA privacy regulations unless this authorization specifically authorizes such disclosure.

Information related to drug and alcohol use in my records is protected under federal regulations and cannot be released without my written consent unless otherwise provided in the 42 Code of Federal Regulations Part 2. All information and records, which identify a person who has AIDS virus infection or who has or may have a disease or condition required to be reported pursuant to the provisions of G.S. 130A-143 shall be strictly confidential. This information shall not be released or made public except under circumstances outlined in G.S. 130A-143.

Client or Legal Guardian (if under age 18) Signature

Date

Witness/Title

Date