Miles Psychological Services, LLC
606 25th Avenue South #105, St. Cloud, MN 56301
320.247.4737 (office) - 320.365.0080 (fax) - www.MilesPsychology.com

Authorization to Release and Disclose Patient Information

Patient Information	Name: _____ Date of Birth:_____ Address: _____ Phone: (_____)_____ City: _____ State: _____ Zip: _____
I authorize	**Miles Psychological Services & Vincent Miles, PsyD LP** 606 25th Ave S. #105 St. Cloud, MN 56301 Phone: (320) 247-4737 Fax: (320) 365-0080
To do the following: ☐ Release to ☐ Receive from ☐ Both	Agency/Name: _____ Phone: (_____)_____ Address: _____ Fax: (_____)_____ City: _____ State: _____ Zip: _____
Information to be released	☐ Any and all medical records ☐ All records dated from _____ to _____ -or- ☐ Verbal Only release the records checked below: ☐ Most Recent Progress Note: _____ ☐ Assessment Diagnostic Form: (3 most recent progress notes & treatment plan) ☐ Psychological Testing Interpretive Report ☐ Itemized Billing Statement ☐ Other: _____ Mental health information, alcohol/drug abuse information, and AIDS related illnesses information appearing in any of the records/information selected about will be disclosed unless indicated otherwise below. ☐ Do not release records/information related to mental health, alcohol/drug abuse, or AIDS related illness. Other: _____
Purpose of release	☐ Coordination of care ☐ Social Security Disability/Appeal ☐ Personal use or review ☐ Insurance payment/claim ☐ Litigation/legal ☐ Other: _____

I understand that it is my right to revoke this consent at any time, either verbally or in writing. I have consented to the release of only the information stated on this form and this information cannot be given to another agency or person without my written consent. It is my right to inspect and receive a copy of the information to be disclosed upon request.

- **I understand there may or may not be a cost related to/associated with this release.**
- I understand this authorization must be filled out completely and signed to be valid.
- This form is in accordance with Federal, State, and HIPAA laws and statutes pertaining to the release of information.
  HIPAA rule section 164.524©. Medicare Program, Photocopying Reimbursement Methodology. 42 CFR Parts 412, 413, 476, and 484. Federal Register Volume 68 no.234 (December 5, 2003)
  Minnesota Health Records Act, regarding authorizations to disclose protected health information. See 45 C.F.R § 164.508©(1) (2002); Minn Stat §§ 13.05, subd. 4(d), 144.335, subd. 3a (2002).

I understand that Vincent Miles, PsyD LP cannot be responsible for the protection of this confidential information once it is shared with another party, and I release him from any liability connected with a breach of confidentiality by the recipient of the information.

_____ Date: _____
Client Signature (if client is 12 or older)

_____ Date: _____
Parent/Guardian Signature (if under 18)