Integrative Behavior Solutions

Authorization to release information

I hereby authorize the individual and/or organization below to release and exchange confidential professional information with Dr. Miller, including but not limited to: educational, psychological assessments, medical information, medications, diagnosis, clinical information, opinions, and/or any other related information that is deemed useful for my care.

I give permission to Dr. Miller to be in communication with:

Name: _____

Relationship _____

Address: _____

Phone: _____ Email: _____

Patient Signature: _____
Printed Name: _____
Date: _____
Date of Birth: _____

Parent Signature (if client under 18): _____
Printed Name: _____
Date: _____

Witness: _____ Date: _____