Miller and Associates Consulting LLC (MAC)
4820 South Mill Suite 101
PHONE: 480-600-0539 FAX: 480-921-2673

# AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Name:_____ Date of Birth:_____

---

I voluntarily authorize _____ to exchange my "PHI" with:(ONE PERSON/ORGANIZATION PER FORM)

Name:_____ Relationship to patient:_____

Address:_____

_____

Phone/FAX:_____

---

Copies of records may be sent via mail or electronically. Disclosure of PHI may be telephonically. Disclosure may relate to alcohol/abuse treatment, behavioral/mental health concerns, communicable disease related information, including records of testing, diagnosis, or treatment for HIV, HIV related disease, AIDS and/or AIDS related disease as applicable. Note: PHI may be subject to redisclosure by recipient.

---

The specific description of the information to be disclosed is entire chart without restriction unless you specify only individual components below:

- ☐ Intake paperwork
- ☐ Informed consent documents
- ☐ Psychological testing
- ☐ Assessments
- ☐ Progress notes
- ☐ Attendance
- ☐ Discharge plans
- ☐ Treatment plans
- ☐ Other (specify:)_____

---

The purpose of, or need for, this disclosure is at the request of the individual for:

- ☐ Continued healthcare
- ☐ Support person/family contact
- ☐ Processing of insurance claim
- ☐ Other (specify):_____

---

This authorization expires on _____. If no date is specified, authorization will expire one year from signature date. I understand that I have a right to revoke this authorization and must do so in writing to: Miller and Associates LLC (address above). Revocation will not apply to information that has already been released pursuant to this authorization. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
PLEASE COMPLETE ALL SECTIONS.

---

_____ _____
Patient Signature Date

_____ _____
Witness Date