Lynn Miller
Counseling

HIPAA Authorization to Release Confidential Information

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Lynn Miller, LPC
571 High Street, Worthington, OH 43085
(614) 702-7011
Lynn@lynnmillercounseling.com

Health Information to be disclosed upon the request of the person named above (*check either A or B*):

A. ☐ **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) for the time period _____to _____.
MM/YR MM/YR

OR

B. ☐ **Disclose** my health record, as above, **BUT do not disclose** the following:
_____

Method of Disclosure (unless another format is mutually agreed upon between my provider and designee):

☐ An electronic record or access through an online portal

☐ Hard copy

☐ Fax

☐ Other _____

This authorization shall be effective until (*Check one*):

☐ All past, present, and future periods

☐ Date or event:_____ unless I revoke it.

(NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

_____ _____
Printed name of the individual giving this authorization *Date of birth*

_____ _____
Signature of the individual giving this authorization *Date*