MINDFULNESS
MATTERS

Kathy A. Miller, LCPC

Authorization for Release of Personal Health Information

This form, when completed and signed by you, authorizes Mindfulness Matters P.C. to release protected information from your clinical record to the person(s) and entities you designate below.

I authorize: Kathy A. Miller, LCPC, Mindfulness Matters P.C., 5225 Old Orchard Rd., Ste 5, Skokie, IL 60077, 224-659-2654

To release to:

Organization: _____

Name: _____

Address: _____

Phone: _____

FAX: _____

Please initial for the following specific information to be released:

Dates of Treatment	Treatment Summary	Treatment Plan
Progress in Treatment	Compliance with Treatment	Nature & Outcome of Treatment
Evaluation Results/Report	Diagnosis, if any	Prognosis

Other: _____

Regarding: _____

DOB: _____

Home Address: _____

Purpose: _____

In signing this form, I understand that:

1. I am under no obligation to sign.
2. Failure to sign will mean that the information will not be requested or released.
3. I have the right to revoke this Authorization at any time by written request; however, my revocation will not be effective to the extent that Mindfulness Matters P.C. has taken action in reliance on the Authorization.
4. I have the right to copy and inspect the information being disclosed.
5. Illinois law prohibits redisclosure of any information disclosed to the recipient pursuant to this Authorization unless the Authorization specifically authorizes such redisclosure.
6. Consequences for refusal to sign this Authorization: _____

Expiration Date: One year from date below or: _____

Recipient aged 12 and over:

Print: _____ Sign: _____ Date: _____

Witness:

Print: _____ Sign: _____ Date: _____

This is a strictly confidential patient medical record. Rediscloure or transfer is expressly prohibited by law.