Danielle Farese Milburn, Ph.D.
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AUTHORIZATION TO DISCLOSE INFORMATION

Patient:
Last Name: _____ First Name: _____ DOB: _____
Address: _____
City: _____ State: _____ Zip: _____

Information Disclosed FROM:

Danielle Farese Milburn, Ph.D.

8910 Village Harbor Drive

Cornelius, NC 28031

Information Disclosed TO: (Attach list if needed)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Information to be Disclosed:
I understand that my name, date of birth, address, age, gender, phone number, and other demographic and insurance information will be included in any release of health or billing information.

☐ Psychological ☐ Educational ☐ Diagnostic ☐ Progress/Office Notes
☐ Psychiatric ☐ Consultation ☐ Personal History ☐ Treatment
☐ Other (Specify):_____

Method of Disclosure:
☐ In-person ☐ Paper copies picked up ☐ Paper copies mailed ☐ Other (Including Fax)

Why is this information being disclosed?
☐ Continuing Treatment ☐ Insurance ☐ Legal Investigation
☐ At the Request of Patient ☐ Other (Specify):_____

Important Information for Patient/Patient Representative:

1. I understand that the person or organization that gets the information may not be a healthcare provider or health plan covered by federal privacy rules. This person or organization may also disclose the information that I have asked to be released. If this occurs I may no longer have any privacy protection.
2. I understand that I may refuse to sign this authorization. My refusal to sign will not change my ability to get treatment, payment for treatment or eligibility for benefits. I may inspect or copy any information that has been either used or disclosed under this authorization.
3. I understand that I have the right to change my mind. I may revoke this authorization at any time by submitting a written request to the Director of the facility where I am sending the Authorization. I understand that I cannot revoke my authorization to the extent Dr. Milburn's office has relied upon it.

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT.

Signature of Patient/Patient Representative: _____ Date: _____
THIS AUTHORIZATION EXPIRES 90 DAYS AFTER THE DATE OF SIGNATURE.

Legal Authority is: ☐ Parent of Minor ☐ Guardian ☐ Attorney in Fact
Patient is: ☐ Minor

Health Information Released by: Danielle Farese Milburn, Ph.D. Date: _____