1320 19th Street, NW, Suite 200, Washington, DC 20036
4831 West Lane, Bethesda, MD 20814
Phone & Fax: 202-629-1949
www.keithmillercounseling.com

AUTHORIZATION FOR PHYSICIAN DISCLOSURE/RELEASE OF INFORMATION

In order to best serve you, it is our standard practice to contact the primary care physician of all new clients. Many times this is simply a professional courtesy and a way to establish coordination of care, if needed, now or in the future. This usually consists of a fax and a brief phone call to let your physician know that you are engaged in our counseling support. We do not share details of your treatment that are not relevant to your physician. We are also willing to send a letter of introduction to physicians should we refer you for a medication consultation. To assist us in this, please provide the following information:

Name of Psychotherapist Requesting Information: ____

Patient Name: ____

Patient Address: ____

____

Patient Date of Birth: ______________________ **Social Security Number:** ______________________

Parent/Guardian/Surrogate Parent Name: ____
(If applicable)

I give my permission for the following individual or agency to obtain and/or release the protected information checked below about me or my child for use in my therapeutic treatment efforts. I understand this information will be private and that my permission is voluntary. At any time, I can revoke this permission by notifying Keith Miller & Associates Counseling in writing. I understand that a revocation will not be retroactive and will not affect disclosures prior to revocation. I understand the information to be released may contain details about any of the conditions/issues for which I am being treated or may be restricted only to generic disclosure about my engagement in counseling, as indicated below. I understand that this information may include medically sensitive material, and I authorize its release for the purposes stated. I understand that information used or disclosed related to this authorization may be subject to redisclosure by the recipient (my doctor) for therapeutic purposes and is subject to the privacy rules of the recipient. I understand I may restrict the release of my information based on my reply below. I understand this information is being obtained for purposes of therapeutic benefit and/or planning.

____________________________________ ____
Your Signature **Date**

PLEASE CHECK ONLY ONE:

☐ I authorize release of information containing details about the conditions and issues for which I am engaged in counseling.

☐ I do NOT authorize release of specific information about my counseling treatment. You may only disclose that I am a client.

Your Doctor's Name: ____

Name of Practice: ____

Address of Practice: ____

City: _______________________________ **State:** _______ **Zip:** _____________

Telephone: ___________________________________

Fax: ___________________________________

The entities allowed to release information are:

Psychotherapist: ________________________

Address: Keith Miller Counseling
1320 19th Street, NW
Suite 200
Washington, DC 20036

Telephone: (205) 629-1949
Fax: (205) 629-1949 (same as above)