



Miller Care Group
 3850 Shore Drive Suite 315
 Indianapolis, IN 46254
 Telephone: 317-429-0061
 Fax Line: 317-222-1953

AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

Instructions: Fill in the appropriate information in each applicable section. Sign, date, and return the form. Incomplete forms will be returned to you unprocessed. A separate authorization must be completed for each request.

Patient Full Name: _____ Date of Birth: _____ Phone Number: _____

Address: _____

I hereby authorize:

Release information or

Exchange information to:

NAME: Miller Care Group	NAME:
ADDRESS: 3850 SHORE DRIVE SUITE 315	ADDRESS:
INDIANAPOLIS, INDIANA 46254	
PHONE: 317-429-0061 FAX: 317-222-1953	PHONE: FAX:

By signing below, I hereby authorize "Facility" or agent, to disclose information contained in the medical and financial record of the patient identified above, which includes information that may be stored in a paper and/or another electronic format. However, such notes may contain information on general medical care; alcohol and drug abuse treatment; psychological and social work counseling; human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS), or AIDS related complex. Including communicable diseases or infections, sexually transmitted diseases, venereal diseases, tuberculosis and hepatitis; demographic information; and treatment received at other health care facilities. Disclosure shall be limited to the following specific information contained in my records and/or obtained during my diagnosis and treatment.

The following information is requested: (patient* or legal guardian items to be released).

- | | | |
|--|--|--|
| <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Financial Account information |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Immunization Records | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Practitioner Orders | <input type="checkbox"/> Medication Records | _____ |
| <input type="checkbox"/> Practitioner Progress Notes | <input type="checkbox"/> Treatment/Individualized Service Plan | _____ |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Discharge Instructions | _____ |

The Purpose or Need for Disclosure is:

- | | | |
|--|--|---|
| <input type="checkbox"/> To Transfer Client Care | <input type="checkbox"/> To Aid in Treatment | <input type="checkbox"/> Application for Provider Coverage |
| <input type="checkbox"/> For Follow Up Care | <input type="checkbox"/> For Discharge Planning | <input type="checkbox"/> Psychological Report |
| <input type="checkbox"/> To Inform Family | <input type="checkbox"/> To Update Medical Records | <input type="checkbox"/> To Aid in financial account activity |
| <input type="checkbox"/> Referral Source | <input type="checkbox"/> Employer | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Legal/Court System | | _____ |

I understand that the information in my health record may include information relating to sexually transmitted disease, immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

State and federal law protect the following information. If this information applies to you, please () indicate if you would like this information released/obtained (include dates where appropriate):

- | | | |
|---|--|--------------|
| Alcohol, Drug, or Substance Abuse Records | <input type="checkbox"/> Yes <input type="checkbox"/> No | Dates: _____ |
| HIV Testing and Results | <input type="checkbox"/> Yes <input type="checkbox"/> No | Dates: _____ |
| Mental Health Records Dates: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Dates: _____ |

Disclosure Format (Paper/US Mail or Fax is default if not marked.): Specify "E-mail" or other Electronic format": _____

- This authorization is valid only if received within 60 days of being signed. This authorization will expire at the time of disclosure of requested information or on _____ (date cannot be more than 180 days after date signed below).
- I may revoke this authorization at any time. Revocations to this authorization must be presented in writing. Revocation will not apply to information disclosed prior to receiving a written revocation.
- I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy laws and regulations.
- I understand Miller Care Group will not condition my treatment, payment, enrollment or eligibility for benefits on whether I provide this authorization.

By signing below, I acknowledge that I am aware of the confidential and/or privileged nature of the information being disclosed and understand the benefits and/or disadvantage of disclosing such information. I hereby release above Facility, its affiliates and its agent and representatives, (including collection agencies) from all legal liabilities that may result from the release of this information according to this request. I also expressly consent and authorize to be contacted by the phone number provided (cellular or residential) by any type of voice method and by auto-dialer technology for any permissible purpose.

Printed Full Name or Authorized Representative _____

E-Signature Full Name or Authorized Representative Signature _____

Date _____

