Don F. Mills, M.D.

Authorization to Release Medical Information to Dr Mills' Office

Section A: Must be completed for all authorizations:
I hereby authorize _____ and/or his/her/staff to disclose my individually identifiable Protected Health Information, as described below. I understand that this authorization is voluntary. I understand that the information disclosed is pursuant to this authorization may be subject to redisclosure by the recipient and my no longer be protected by federal and state law**.**

Patient Name: _____ Date of Birth: _____
Organization receiving this information: **Don F. Mills, M.D.**
Specific description of information to be disclosed, including specific dates:
_____
_____

Section B: Must be completed for all authorizations:

1. I understand that my file may contain information about transmittable disease such as HIV, AIDS, Hepatitis: _____ (Initial).
2. I understand that my file may contain information about psychiatric conditions, such as depression: _____ (Initial).
3. I understand that my file may contain information about drug and/or alcohol dependencies: _____ (Initial).

Section C: Must be completed for all authorizations:

The patient or patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on ____/____/____.
2. I understand I may revoke this authorization at any time by notifying Don F. Mills, M.D., in writing but, if I do it won't have any effect on any actions taken before the receipt of my revocation. _____ (Initial).

Don F. Mills, M.D. will not condition my treatment on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating PHI for disclosure to a third party.

_____ _____
Signature of patient or patient's representative Date

_____ _____
Printed name of patient and/or representative, if applicable Relationship