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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Authorization is hereby granted to Nathan J. Miles, PhD to exchange relevant clinical information with:

Name of person/organization: _____

Address: _____

_____

Telephone: _____ Fax: _____

This information may be transmitted:
___ in person ___ by telephone ___ by letter ___ by email ___ via fax

Whenever possible, non-cellular phones or US mail are used to convey confidential information because they are considered more secure.

The following information will be disclosed:
___ Psychotherapy Treatment Summary

___ Substance Abuse Treatment Summary

___ Psychological Assessment Report

___ Ongoing consultation (in person, or by mail or telephone)

___ Other (specify): _____

For the purpose of _____

_____

I understand that I may revoke this consent at any time. Upon fulfillment of the above stated purpose(s), this consent will automatically expire without my express revocation on:

_____
DATE AUTHORIZATION EXPIRES (authorization is void without an expiration date)

Name (printed): _____

Signature: _____ Date: _____

Witness: _____ Date: _____