Helene Miller MD LLC
Family Psychiatry of North Jersey
351 Evelyn Street, Paramus, NJ 07652
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Authorization to Release Information

We need your authorization to release your medical information to your insurance companies so that we can determine your benefits, initiate treatment, receive authorization for continued treatment, and receive payment for services rendered.
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I, ________________, authorize Helene Miller, MD, LLC and Family Psychiatry of North Jersey to release my medical information (or information for my child, _______) to Medicare and/or my insurance company to determine my benefits, initiate treatment, receive authorization for continued treatment, and receive payment for services rendered.

AUTHORIZATION TO RELEASE OT OTHER PROFESSIONALS (OPTIONAL)
In addition, we may need your authorization to release information to certain professionals (e.g., physician, therapist, attorney, etc…) involved in your treatment so that we can collaborate and provide more comprehensive care. You may revoke this authorization at any time in writing, except if we have already taken action based on the authorization

I also authorize the release of my medical information to the following parties:

Name ________________Type of Professional ________________
Phone ______________ Address________________________________

By signing this release, I understand that information will be disclosed regarding my HIV/AIDS status, regarding my mental health and /or substance abuse history. By executing this document, I specifically agree to the disclosure of such information. I understand that the information used or disclosed may be subject to re-disclosure by the person or persons or facility receiving it, and would no longer be protected by federal privacy regulations.
I understand that I may inspect or copy the protected health information to be used or disclosed. I understand that I may refuse to sign this authorization and that this decision will not impact treatment or payment for services.
I may revoke this authorization at ANY TIME by notifying that medical provider listed above in writing of my desire to revoke it. However, I also understand that any action already taken in reliance on this authorization cannot be revered, and my revocation will not affect that action. This authorization expires ONE YEAR FROM THE DATE OF EXECUTION.
Signature of Patient______________________ Print Name___________________________
Date: ___/___/______*This release will expire 12 months from signature date unless otherwise written*

Signature of Parent/Guardian (if a Minor) _______________Print Name____________
Print name of Minor_________________________ Date: _____/____/_______