Erin C. Milhem, Psy.D.
Licensed Clinical Psychologist
528 E. Spokane Falls Blvd., Suite 26A
erincmilhem@gmail.com

I authorize mutual exchange of information between_____ and Erin Milhem, Psy.D.to discuss and release protected health and educational information regarding _____ (DOB:_____) for the services provided between _____ and ending _____.

Information to be disclosed:

- All records
- Summary of Medical History and Treatment
- Psychological Testing
- Evaluation Report
- Clinic Notes
- Educational Information
- Individualized Education Plan (IEP)
- Other: Please Specify _____

I understand that information in my health record may include information relating to behavioral or mental health services, HIV/AIDS, sexually transmitted disease, drug and/or alcohol abuse. I give my specific authorization for these records to be released.

This authorization expires after 90 days, except when authorizing release to 3rd party payers

I understand that I may revoke this authorization by submitting a written request to Erin Milhem, Psy.D. at any time except to the extent that action has already occurred based on the original authorization or when the authorization is required as a condition of obtaining insurance coverage and the insurer can contest the policy or a claim under the policy. RE-DISCLOSURE PROHIBITED FOR CERTAIN INFORMATION: Once disclosed, the law does not always require the recipient of your information to maintain the confidentiality of your health care information. However, I will maintain the confidentiality of your information. Also, if you authorize the disclosure of health information containing sexually transmitted disease information, state law prohibits re-disclosure (Ch 70.24 RCW). If you authorize disclosure of information containing drug or alcohol treatment information, re-disclosure is prohibited by federal law (42 CFR Part 2). I understand that I have the following rights: a) to inspect or copy protected health information, b) to receive a copy of this signed authorization, and c) to refuse to sign this authorization.

By signing this page, I acknowledge that I have read and agree to the terms on this form.

_____
Printed Name

_____
Client Signature (if over 13 years of age) Date

_____
Printed Name

_____
Parent/Guardian Signature (if under 13 years of age) Date