PEACE OF MIND CENTER, LLC
Matthew R. Mills, M.D. • Psychiatrist

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize *Matthew R. Mills, M.D.*, to speak with and / or share information with the following person or agency:

Name: _____

Phone: _____

This data may include information concerning HIV/AIDS, mental health, developmental disabilities, and alcohol / substance abuse, complete psychiatric history including diagnoses, dates treated, medication history, laboratory and test results, and any other pertinent information as follows:

Regarding (please write your name and date of birth): _____

_____ for the purpose of continuity of care.

I understand my refusal to consent to the release of the above mentioned information will prevent the disclosure of the information, and may result in poor continuity of care.
I understand that I have the right to inspect and copy the information that I have authorized for release at any time by writing to Peace of Mind Center, LLC. If not revoked, this authorization will expire 365 days from the date signed.

_____ _____
Patient signature Date

_____ _____
Signature of patient's guardian or representative (if applicable) Date

_____ _____
Matthew R. Mills, M.D. Date

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