Robert B. Miller, EdD LP

Child and Pediatric Psychologist
Office: (989) 780-0174
Fax: (989) 790-7182

I. I give Dr. Robert Miller permission to provide psychological consultation, evaluation and/or treatment services to my minor child _____________________ DOB: ______________. I understand consultation and evaluation are provided on a fee for service basis and guarantee payment on date of service provision unless prior arrangements are made.

_________________________ ___________________
Parent Date

II. I give Dr. Robert Miller permission to talk with me, provide psychological consultation services, evaluation, and/or treatment and my privileges under this agreement have been explained to me. (If child is >13 years old).

_________________________ ____________________
Minor Date

III. I give Dr. Robert Miller permission to release diagnosis and treatment recommendations to my parents. I give Dr. Robert Miller permission to discuss me with ___________________ . (If child is >13 years old).

_________________________ ____________________
Minor Date

IV. I give Dr. Robert Miller permission to discuss my child and release records and obtain information and records for one year with (This is a HIPAA RELEASE usually for the primary care provider and/or specialty physician/hospital).
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____.
and/or (This is a FERPA RELEASE for school psychologist or administrator of your child's school, if appliable).
____.

This includes all diagnostic impressions and treatment recommendations and records as warranted.

_________________________ ___________________
Parent Date