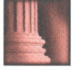

ALAN KARBELNIG, PH.D.

Psychotherapy
Psychoanalysis &
Psychological
Assessment

Consent and Authorization to Use or Disclose Information

I, _________________________ (Patient), hereby authorize Alan Karbelnig, Ph.D. to disclose information and records obtained in the course of my psychotherapy treatment to:

Name:____

Address:____

City/State/Zip:____

Phone/Fax:____

I understand that I have a right to receive a copy of this authorization and that any cancellation or modification of this authorization must be provided by me in writing and received by Alan Karbelnig, Ph.D., at 625 Fair Oaks Avenue, Suite 270, South Pasadena, CA 91030 to be effective. I understand that I have the right to revoke this authorization at any time unless Dr. Karbelnig has already taken action in to cancel this authorization.

The purpose of information and records disclosure:

____

The specific uses and limitations of the information to be disclosed:

____

I understand that I have the right to refuse consent and signing of this authorization and Dr. Karbelnig shall not condition my treatment with this refusal.

625 FAIR OAKS AVENUE, SUITE 270
SOUTH PASADENA, CA 91030-2630
PHONE 626-441-7778
FACIMIE 626-441-4893
PSYCHOLOGIST-PSY 10347
TAX I.D. NO. 95-4227991

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable California law may protect such information.

This authorization shall remain valid for:
o 1-year from date indicated below
o Terminate on date: ____________

Signature of Patient: __________________________________ Date: ____________

A Xerox and/or facsimile copy of this authorization shall be valid as the signed original on file.