Authorization to Release Psychotherapy or Psychological Evaluation Records

(HIPPA Compliant)

Psychotherapy
Psychoanalysis &
Psychological
Assessment

ALAN KARBELNIG PhD

I, _____
(Patient)

authorize _____
(Psychologist)

to release my psychotherapy or psychological evaluation information as follows:

A. Specific information requested and its intended use, i.e. to whom and for what purposes: _____

_____

B. Length of time the information will be kept before being destroyed or disposed of: _____.

(I understand that, in order to keep the information longer than the time specified, I must be notified of the extension and the specific reason for the extension, the intended use of the information during the extended time and the expected date of the destruction of the information.)

Authorization Ends on This Date: _____

C. I understand that the information will not be used for any purpose other than its intended use.

D. I understand that the person/entity requesting the information will destroy it and all copies of it, will cause it to be destroyed, or will return it and all copies of it to me, before or immediately after the length of time specified in item B (above) has expired.

E. I have received a copy of this written request prior to the sending of the requested information.

F. The professional (above) is not authorized to disclose information to any other person/entity without my consent.

G. I understand that I may revoke this authorization at any time.

Name [printed]: _____

Signature: _____

Date: _____

[Revised March 2015]

117 EAST COLORADO BOULEVARD | SUITE 425
PASADENA CA 91105-3729
PHONE 626 441 7778 | FACSIMILE 626 441 4893
AMKARBELNIG@GMAIL.COM | ALANKARBELNIG.COM
PSYCHOLOGIST – PSY10347