Gharabeki Psychological Services, Inc
600 N Rosemead Blvd Suite #204
Pasadena, CA 91107
(818) 233 – 0583
contact@drgharabeki.com

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH RECORD

CLIENT INFORMATION	
Name:	Date of Birth:

I hereby authorize the following named individual or organization,

RELEASING AGENCY
Gharabeki Psychological Services, Inc 600 N Rosemead Blvd Suite #204 Pasadena, CA 91107 Phone: (818) 233 – 0583 Email: contact@drgharabeki.com

to release, discuss, and/or disclose the following protected health information *(check one)*:

- o Full treatment record including all health/mental health information
- o Other: _____

for the purposes of *(check one)*:

- o Coordination of Care
- o Legal
- o Education
- o Personal Use
- o Financial
- o Other (please specify): _____

In compliance with California Statues which require special permission to release privileged information; please initial if any of these conditions are applicable:	
Initial Here: _____	HIV Test Results
Initial Here: _____	Alcohol or Drug Facility Treatment Records

I authorize this information to be shared with the following named individual or organization:

RECEIVING AGENCY	
○ Self ○ Parent/Legal Guardian ○ Health Care Provider ○ Other (please specify): _____	
NAME	
ADDRESS	
PHONE	
EMAIL	
FAX	

This authorization is effective immediately and shall remain in effect for twelve (12) months from the date of signature or until ____/____/____.

I understand:

- Authorizing the disclosure of the information identified above is voluntary.
- I may revoke this authorization at any time by notifying Gharabeki Psychological Services, Inc in writing at the address indicated above. My revocation will not apply to information already retained, used, or disclosed in response to this authorization.
- If the person(s) and/or organization(s) authorized by this form to receive my health information are not health care providers or other people who are subject to federal health privacy laws, the health information they receive may be subject to re-disclosure and no longer be protected by the federal confidentiality law.
- I may refuse to sign this authorization without it affecting my ability to obtain treatment. However, lack of ability to share or obtain information may prevent Gharabeki Psychological Services, Inc and/or the other named person, facility or agency, from providing appropriate and necessary care.
- I have the right to request a copy of this authorization form.
- I may inspect or obtain a copy of the health information that is the subject of this authorization as stated in the HIPAA privacy policy.
- Extra charges may apply for certain information requests and selected methods of delivery as noted in the office policies.

SIGNATURE

X_____ _____

Signature of Client/Legal Representative Date

_____

Printed Name

If signed by a legal representative, please indicate type of authority (e.g., court appointed, custodial parent): _____