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Authorization Form

The federal Health Insurance Portability and Accounting Act (HIPAA), effective 14 April, 2003, allows that you may authorize Dr. Garber to communicate protected health care information from your clinical record or from that of a minor child for whom you are legal guardian to specified individuals or agencies.

For more information about your rights under HIPAA go to <http://www.cms.gov/hipaa/> write to Centers for Medicare & Medicaid Services 7500 Security Boulevard, Baltimore MD 21244-1850 or call toll-free: 877-267-2323

I _____ (please print your full name) authorize Benjamin D. Garber, Ph.D., to release information regarding confidential records:

- About my INDIVIDUAL psychotherapy or assessment and related records
- About my participation in psychotherapy with another person (for example: marital, couples, co-parenting, family or group therapy). I understand that without the written authorization of the other person(s) involved in this psychotherapy or assessment, these records may be edited or ineligible for release.
- About a minor child for whom I am legal guardian

This information should only be released to:

(name and address of person to whom the information is to be released)

I am requesting Dr. Garber to release this information for the following reasons: ("at the request of the individual" is all that is required if you are my patient and you do not desire to state a specific purpose.)

At my personal request

Or specify here:

This authorization shall remain in effect until one year from today's date unless otherwise specified:

I wish to specify that this authorization will expire on: _____
(month/date/year)

I am aware that I have the right to revoke this authorization, in writing, at any time by sending written notification to Dr. Garber's office address. I am aware that any such revocation will not be effective to the extent that Dr. Garber has taken action in response to this authorization or if otherwise required by legal contract, mandate or court order.

I understand that Dr. Garber may not condition the provision of services upon receipt of an authorization to release or receive confidential information unless such release/receipt has been established in writing as a precondition for services or the services provided are for the purpose of generating health related information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Please print your name in full

Please sign your name

Please print the PATIENT's name in full if
you are not the patient

Please print your relationship to the patient if
you are not the patient

Please print today's date

Please print the PATIENT's date of birth