Lisa Karabelnik, MD
345 North Main Street, Suite 317; West Hartford, CT 06117
Phone: (860) 521-3380

Authorization to Release/Obtain Information

I, ____hereby request and authorize __Lisa Karabelnik, M.D.___ to release/obtain the following information via mail, fax, telephone, or e-mail __psychological testing, psychiatric evaluation, medical history, medication history, and educational information_ concerning ______________________ Date of Birth ____________ to (name and address/ phone number of person/agency information is to be released to) ____

This information 'will be released for the following purpose: eval. and continued care

Dates of treatment, evaluation, education covered by this release:___all_____________

Records to be released may contain information pertaining to psychiatric, psychological, neuropsychological, drug and/or alcohol diagnosis and treatment. The records to be released may also contain confidential HIV/AIDS related information. Educational records may also be released. I may withdraw this consent at any time prior to the release of the above information. This consent, if not withdrawn, will expire within 365 days after it is signed or on the following date: ______________________

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, our revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of helping you obtain reimbursement from your insurance company and the insurer has a legal right to contest a claim. I understand that my psychiatrist generally may not condition psychiatric services upon my signing an authorization unless the psychiatric services are provided to me for the purpose of creating health 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 HIPPA Privacy Rule.

______________________ ________________________________ _______________

Signature of Patient Signature of Parent or Guardian Date

______________________ ________________________________

Witness Relationship