Carole W. Sebenick, Ph.D.
Licensed Clinical Psychologist
3949 Pender Drive, Suite 301, Fairfax, VA 22030, (703) 362-9313
CWSebenick@CWSebenickPhD.com (secure/encrypted)

Consent to Release Confidential Information

_____ _____
Patient Full Name Patient Date of Birth (mm/dd/yyyy)

I, _____, do hereby authorize release of confidential information in the possession of Carole W. Sebenick, Ph.D., to the following entity:

_____ _____
Name of Individual, Company, Agency, or Facility Phone Number

_____ _____
Mailing Address Fax Number

_____
City, State, Zip Code

Disclosure may include the following types of information:

___ All treatment records
___ Dates of treatment and diagnosis
___ Summary of treatment
___ Current treatment issues/progress
___ Specific information to include: _____

Information will be released for the following purpose(s):

___ Coordination of care
___ Billing and payments
___ Referral to specialist
___ Family/ally support of treatment
___ Request for academic/workplace support/accommodation
___ Other (specify)_____

I understand that I am giving my permission to Carole W. Sebenick, Ph.D., to disclose protected health information. I also understand that I have the right to revoke this consent, but that my revocation is not effective until provided in writing to Dr. Sebenick or specified by my initials below.* The person who receives the records/information to which this consent pertains may not disclose them/it to anyone else without my separate written consent unless such recipient is a provider who makes a disclosure permitted by law. I hereby release Carole W. Sebenick, Ph.D., from any legal responsibility that may arise from the release of the requested information. I understand that fees may apply, if release of information entails significant professional time and/or document preparation.

_____ Date: _____
Signature of patient (or, if under age 18, Parent/Legal Guardian)

_____
Printed name

*CONSENT WITHDRAWN ON _____. PATIENT INITIALS: _____