Gretchen Kubacky, Psy.D., Inc.
California License PSY 21917
NPI #1780931949

Consent and Authorization to Use or Disclose Information

I, _____ (Client), hereby authorize Dr. Gretchen Kubacky to disclose information and records obtained in the course of my psychotherapy treatment to:

Name: _____

Address: _____

City/State/Zip: _____

Phone/Fax: _____

I understand that I have the right to receive a copy of this authorization and that any cancellation or modification of this authorization must be provided by me (Client) in writing and received by Dr. Gretchen Kubacky at 10883 Arizona Avenue, Culver City, CA 90232 to be effective. I understand that I have the right to revoke this authorization at any time unless Dr. Gretchen Kubacky has already taken action to cancel this authorization.

The purpose of information and records disclosure:

- ☐ Obtain or provide history
- ☐ Treatment planning
- ☐ Billing/payment/insurance coordination
- ☐ Review/discuss diagnosis
- ☐ Coordination of care
- ☐ Other: _____

☐ No exclusions **OR** ☐ the specific uses and limitations of the information to be disclosed:

_____

I understand that I have right to refuse consent and signing of this authorization and Dr. Gretchen Kubacky shall not condition my treatment with this refusal.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable California law may protect such information.

This authorization shall remain valid for:

Days (not to exceed 365) **OR** 1-year from date authorization signed below.

Signature of Patient: _____ Date: _____

A photocopy and/or facsimile copy of this authorization shall be valid as the signed original on file.