Gina M. Garbell, Psy.D.
Licensed Psychologist

Consent to Disclosure of Confidential Information to Managed Care Company

As a provider under contract with the managed care company providing my mental health care benefits, I acknowledge that **Gina M. Garbell, Psy.D., Licensed Clinical Psychologist**, must necessarily disclose information regarding my care to this company. Once the information is submitted, I have been advised and understand that **Gina M. Garbell, Psy.D**., will have no control over it and cannot guarantee it will be appropriately safeguarded by the company, nor can she control how the information will be used. I understand that she may be asked to share with the company *all* information in my file, including her personal case and progress notes.

I hereby consent for **Gina M. Garbell, Psy.D**., and members of her staff to disclose any and all information regarding my mental health care treatment, including but not limited to her case and progress notes, requested by the managed care company that provides my mental health care benefits, upon request by that company.

This information is to be provided at my request for use by my managed care company for determining coverage, benefits, and payment of mental health services. This authorization shall expire upon the termination of my therapeutic relationship with **Gina M. Garbell, Psy.D.**, and payment to her by the managed care company of all fees charged for the services she provides to me. I acknowledge that I have the right to revoke this authorization in writing at any time to the extent **Gina M. Garbell, Psy.D.**, has not taken action in reliance on this authorization. I further acknowledge that even if I revoke this authorization, the use and disclosure of my protected health information could possibly still be disclosed under law to secure payment for the services provided as indicated in the copy of the HIPAA Notice of Privacy Practices of **Gina M. Garbell, Psy.D.**, that I have received and reviewed.

I acknowledge that I have been advised by **Gina M. Garbell, Psy.D.**, of the potential of the redisclosure of my protected health information by the authorized recipients and that it will no longer be protected by the federal Privacy Rule.

I further acknowledge that the treatment provided to me by **Gina M. Garbell, Psy.D.**, was conditioned on my signing this authorization and my choice to not personally pay for the services provided by her.

_____ _____
Client Signature (Parent/Guardian if client is under age 18) Date

_____ _____
Psychologist's Signature Date