Penson Psychotherapy Solutions, Inc.

Abby Penson, Ph.D.

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Authorization to Use, Disclose, and/or Receive Protected Health Information

Client Name: ____
Address: ____
Date of Birth: ______________________________ Date of Request: __________________

As required by the Privacy Regulations, I may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.
I hereby authorize Abby Penson to use, disclose and/or receive Client Health Information with the following person(s), entity(s), or business associates of this office:

____

Client Health Information authorized to be disclosed may include any or all of the following:

- School Transcripts and Records
- Medical Records
- Discharge Summaries
- Psychological Evaluations
- Therapy/Counseling Records
- Psychiatric Evaluations
- Telephone communication
- ____

-I authorize information to be faxed: Patient or Parent / Guardian initials: ___________

For the specific purpose of (describe in detail): ____

Effective dates for this authorization: _____/_____/_____ **through** _____/_____/_____
This authorization will expire at the end of the above period.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any compensation involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Client Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

   I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected client health information.

____ ______________
Signature of Client or Client's Authorized Representative Date

____ ______________
Abby Penson, Ph.D. Date

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