Authorization for Release of Information

I, ________________________________, (________________), do hereby authorize __Penny Michelle Abrams, PhD___

First, Middle, Last Name (client/parent) DOB

to exchange information contained in my medical record, in either verbal or written form, and/or by fax, with:

Name of Person or Agency: ____

Address: ____

Street Address City State ZIP

Telephone: ______________________________ Fax Number: ______________________________

Permission is hereby granted to provide information to the above specified person(s) or agency regarding:

_____ COMPLETE RECORD _____ VERIFY TREATMENT ONLY

_____ TREATMENT SUMMARY _____ PSYCHOLOGICAL TESTING

_____ FOR PURPOSE OF: ____

I give permission for information to be released in written or verbal form, or via fax, to the above specified individual or to personnel at the above specified agency. I understand that this Authorization will expire one year from the date of signature below, unless specified otherwise. I understand that I have the right to request an accounting of any instances that information is released to other parties. I understand that this Authorization may be revoked at any time.

Expiration Date____________________

Signature: ____ Date: _______________

Witness: ____ Date: _______________

FOR INTERNAL USE ONLY

(document date and reason for revoking release of information)

Date Revoked: ______________ Signature: _____________________________

Penny Michelle Abrams PhD
PO BOX 676148 Rancho Santa Fe, CA 92067
713-906-9057 sixtyminutesofclarity@gmail.com
CA Psy 20753 NY Psy 18982 FL Psy 10295
sixtyminutesofclarity.com