Authorization for Disclosure of Confidential Mental Health Information (HIPAA)

Client's name: ____

Parent or Guardian's name: ___________________________________

Home address: ____
City, State, zip code: _______________________________________

Jenny L Ponzuric, Licensed Educational Psychologist 2779, is authorized to release and disclose information to and receive information from:

Disclosing Person(s)/Educational Institution: ________________________________
Address: ____
City, State, zip code: ____
Phone Number: ____________________ Email: ________________________________

Specific information to be released/obtained:
☐ All health/mental health information, including diagnosis and treatment received
☐ All educational/psychoeducational reports, notes, protocols, emails, student files, and other

Specify what, if any, information is to be excluded:
____

This disclosure of information is required for the following purpose:
____

I hereby authorize and request Jenny L. Ponzuric to obtain information for the psychoeducational evaluation/counseling/consultation/intervention of the above-named client from the following person/educational institution indicated above by phone, electronic mail (email), or in person. I understand that such communication may enhance the quality of the evaluation or services for the client and that all communication will be held confidential by Jenny L. Ponzuric.

Jenny L Ponzuric, LEP #2779
6303 Owensmouth Avenue, 10th Floor, Suite 1055
Los Angeles, CA, 91367-2263
(818) 481-6089

This authorization shall become effective on ___/____/____ and will expire in one year. A photocopy or facsimile of this form is to be considered as valid as the original.

Client Rights

- The client may refuse to sign this authorization.
- The client may revoke this authorization in writing to Jenny L, Ponzuric, LEP; the revocation will be effective only when it is received. However, this revocation will not extend to information that was already obtained or released prior to the revocation.
- The client has the right to receive a copy of this authorization.
- The client may inspect or obtain a copy of their mental health information within the limits of state (California) and federal laws.

Receiving Person: Jenny L Ponzuric, LEP #2770
jenny@ponzuriclearningsolutions.com
(818) 481-6089

Type of Health Care Provider receiving the information:
Licensed Educational Psychologist

______________________________ ____________________
Client Signature (if 18 years or older) Date

______________________________ ____________________
Parent Signature (if client is under the age of 18) Date

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