

# *Penner, Loewen & Symingtons*

Clifford Penner, Ph.D.  
Joyce Penner, M.N., R.N.  
Irene L. Loewen, Ph.D.  
Scott H. Symington, Ph.D.  
Melissa F. Symington, Ph.D.  
Sibylle Georgianna, Ph.D.  
Amanda L. Scott, Intern

200 E. Del Mar Blvd  
Suite 126  
Pasadena, CA 91105  
(626) 449-2525  
(626) 564-1250 Fax

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## **Authorization for Release of Information**

Client's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

I hereby authorize \_\_\_\_\_ to obtain from:

Name of Agency: \_\_\_\_\_

Attention: \_\_\_\_\_ Position \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

The following specified information contained in the medical and/or behavioral records of the above-named client(s) is requested:

Any testing results, diagnoses or psychotherapy notes/summaries

\_\_\_\_\_

Purpose of Request:

\_\_\_\_\_

AUTHORIZED EXPIRATION DATE: \_\_\_\_\_

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness (or Parent/Guardian)

\_\_\_\_\_  
Date