

Fredric Provenzano, Ph.D., NCSP

Private Practice in Psychology

5506 33rd Ave. NE, suite D
Seattle, WA 98105

Fredric Provenzano, Ph.D., NCSP, *Psychologist, WA lic. # PY00001022*
Lauren Christophersen, *Office Coordinator*

Phone: 206/361-2343
Fax: 206/361-0353
www.drfredprovenzano.com

DIRECTIONS TO OFFICE

Our office is located just up the hill from University Village Shopping Center, one block south of Bryant Elementary School and just east of Queen Mary's Tea Room, Ravenna Volvo, and the original Kidd Valley Hamburgers. There is a fire station at the corner of NE 55th and 33rd Ave. NE. Our offices are in the condominium building directly across the street from the fire station. The entrance to our office is located on the ground floor, directly across the street from the fire station's driveway. The map below is provided for your reference.

There is no dedicated off-street parking, but there is ample space available on either 33rd Ave. NE or on NE 55th Street. This office is served by Metro bus lines #74 (with a stop just across the street on NE 55th) and #65 (stopping two blocks east, at NE 55th Street and 35th Ave. NE).

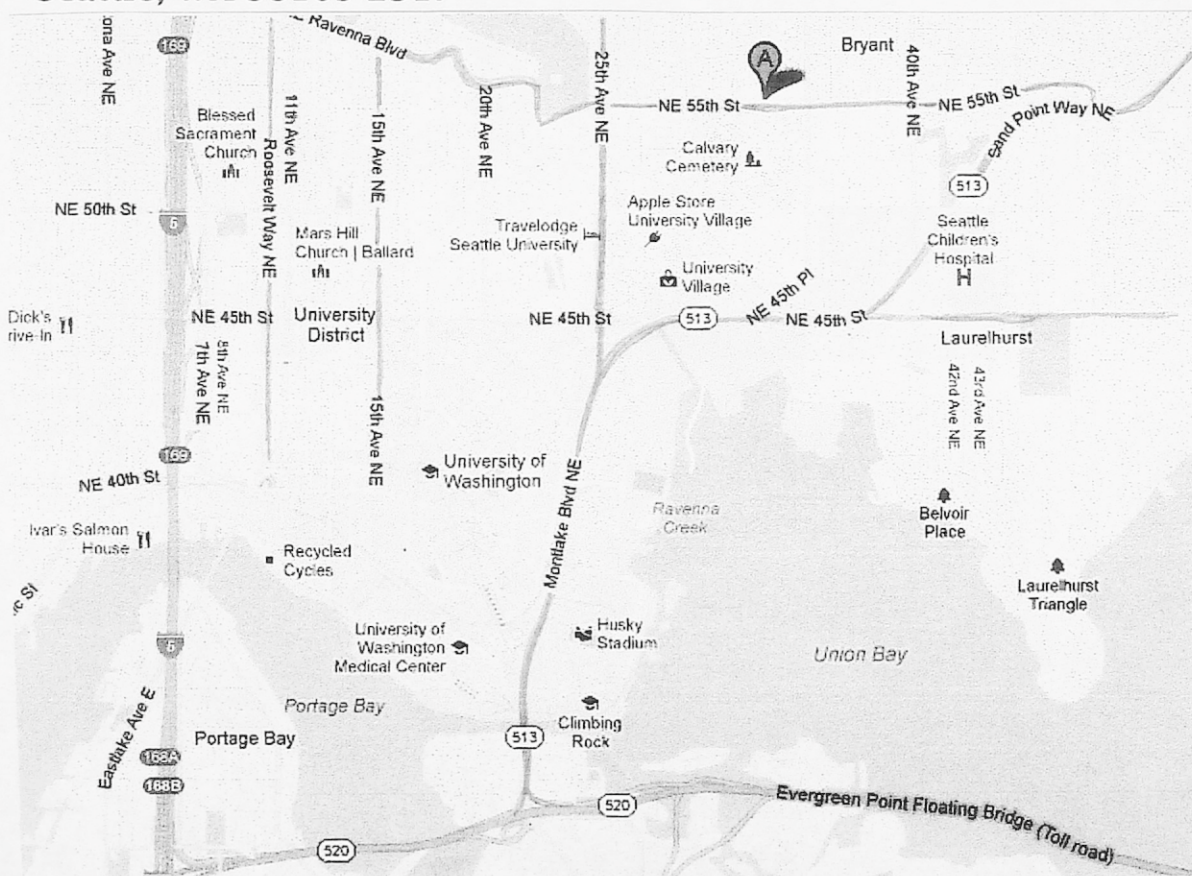
Next scheduled appointment is for _____

on _____ at _____.

Additional Appointment(s): 1. _____

2. _____

* 5506 33rd Ave NE
Seattle, WA 98105-2317



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Authorization for Disclosure/Exchange of Information

Re: _____ Birthdate: _____

This form when completed and signed by you, authorizes us to release and/or receive protected information from your clinical record or the record of the person for whom you are guardian, to the person you designate.

I authorize my psychologist Fredric Provenzano, Ph.D., NCSP and/or his or her administrative and clinical staff to share the following: (Describe the information you want disclosed. Please be as specific and detailed as possible.)

_____ Information only TO Dr. Provenzano

_____ Information only FROM Dr. Provenzano

_____ Exchange of information between Dr. Provenzano and the listed party

To be disclosed: _____

This information should only be disclosed, as per the instructions above, to/from the following:

Name: _____

Organization: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Fax: _____

Reason for Request:

_____ Coordination of Care _____ Authorization of Treatment _____ Claims Processing

_____ Other (describe): _____

This Authorization shall remain in effect until (date) _____ or until the event listed below that relates to the purpose of the disclosure. In any case, it does not permit disclosure of my future health care given more than 90 days from the date of this Authorization (unless this is for disclosure to insurance companies). *If this Authorization does not contain an expiration date, the Authorization expires 90 days from the date of my signature.*

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to my psychologist's office address. However, my authorization will not be effective to the extent that the psychologist has taken action in reliance on my authorization, or if this Authorization was obtained as a condition of obtaining insurance and the insurer has a legal right to contest a claim.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. I also understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

Signature of Patient/Guardian

Date

Co-Signature (if requested)

If the Authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.