Amy M. Cohen

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AUTHORIZATION FOR RELEASE OF INFORMATION

I/We _____ hereby consent to and authorize

Amy M. Cohen, LCPC to release and receive information from

Name of Person: _____

Phone Number: _____

Address: _____

_____

Please circle the appropriate category

TREATMENT PLAN

PSYCHIATRIC DIAGNOSTIC/ADMISSION

PSYCHOLOGICAL/EDUCATIONAL ASSESSMENT

OTHER_____

DISCHARGE SUMMARY

MEDICATION/LAB DATA

LATEST PHYSICAL EXAM

It is understood that any providers who receive this information will not release it to any other party without express written consent, or otherwise in accordance with the law, and will share only that information which is necessary for treatment purposes. In addition, I may revoke this authorization at any time by a written statement.

_____
Signature of Client/Guardian of client if a minor

_____
Amy M. Cohen, LCPC

Date of Consent:

Date of Expiration: