B. Beth Cohen, Ph.D., Licensed Psychologist, PLLC
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Release of Information Authorization

I, _____, DOB _____, hereby authorize B. Beth Cohen, Ph.D. to (select one) ❑ release to ❑ obtain from ❑ exchange with

Name _____

Address _____

Telephone _____ Fax _____

The following information:

- ❑ Information stating **only** that I am a client of Dr. Cohen
- ❑ Any and all of the following**:**
- ❑ My attendance in therapy
- ❑ My diagnosis/assessment
- ❑ My treatment plan
- ❑ Clinical issues
- ❑ Demographic information
- ❑ Prognosis
- ❑ Progress Recommendations
- ❑ Treatment summary
- ❑ When treatment is terminated and why
- ❑ Other (please specify): _____
  _____

For the purpose of:

- ❑ Personal
- ❑ Contact with referral source
- ❑ Family involvement
- ❑ Further psychological evaluation or care
- ❑ Continuity of, or coordinating, treatment
- ❑ Claim reimbursement/insurance authorization/utilization review
- ❑ Other: _____

Expiration: This consent will expire (select one) ❑ upon fulfillment of the purposes stated above.
❑ cancelled ❑ one year from the date below. ❑ my work with Dr. Cohen is completed.

Conditions: I understand that Dr. Cohen will provide me treatment whether or not I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: _____

Form of Disclosure: Unless I specifically requested in writing that the disclosure be made in a certain format, Dr. Cohen reserves the right to disclose information permitted by this authorization in any manner that she deems appropriate, including, but not limited to, verbally, in paper format, or electronically.

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications for their release. This request is entirely voluntary on my part. (Revocation) I understand that I may take back this consent at any time, except to the extent that action based on this consent has already been taken. In consideration of this consent, I hereby release the above parties from any legal liability resulting from the release of this information.

_____	_____	_____
Signature of client	Printed name	Date
_____	_____	_____
Signature of guardian/parent/representative	Printed name and relationship	Date
_____		_____
Signature of Dr. Cohen		Date