Barbara L. Cohen, PsyD
4840 Beck Road
Emmaus, PA 18049
610-530-0100

RELEASE OF INFORMATION/REQUEST FOR INFORMATION

Date of Request:_____
Name of Patient:_____
Patient D.O.B.:_____

Information to be released by:
Dr. Barbara L. Cohen
4840 Beck Road
Emmaus, PA 18049
610-530-0100

Information to be sent to:
_____
_____
_____
_____

and/or

Information to be released by:
_____
_____
_____
_____

Information to be sent to:
Barbara L. Cohen, PsyD
4840 Beck Road
Emmaus, PA 18049
610-530-0100

Information to be released:
_____Medical records
_____Psychotherapy treatment records
_____Other treatment records (please specify)_____
_____Psychological/Neuropsychological Evaluation
_____Other (please specify)_____
Comments (if any)_____

Purpose for release of information:_____

I understand I may revoke this authorization (except to the extent that action has already been taken) by written or oral communication. I understand it is my right to inspect the information which has been released. Furthermore, I consent to the disclosure of information, if any, related to my drug or alcohol abuse or dependency provided that disclosure is limited to (1) medical purpose of diagnosis and treatment; and (2) government or other official exclusively for the purpose of obtaining benefit. I understand that I am not required to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I understand that if the person or entity that receives this information is not the health care provider or health plan covered by federal privacy regulations that the information described above may be re-disclosed and is no longer protected by these regulations.

I certify that this form has been explained to me and I understand its content. Unless indicated otherwise, this Release of Information is valid for one year from the date of signature.

_____ _____
Signature Date