Barbara L. Cohen, PsyD
211 S. Route 100
Allentown, PA 18106
610-530-0100

REQUEST FOR INFORMATION/RELEASE OF INFORMATION

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

Information to be released by:
Dr. Barbara L. Cohen
211 S. Route 100
Allentown, PA 18106
610-530-0100

Information to be sent to:
_____
_____
_____
_____

and/or

Information to be released by:
_____
_____
_____
_____

Information to be sent to:
Dr, Barbara Cohen
211 S. Route 100
Allentown, PA 18106
610-530-0100

Information to be released:
_____Medical Records
_____Psychotherapy Treatment Records
_____Other Treatment Records (please specify)_____
_____Psychological/Neuropsychological Evaluation
_____Hospital Records
_____Psychiatric _____Medical dates: _____
_____Educational Records
_____Other (please specify)_____
Comments if any: _____

Purpose for release of Information:_____

I understand I may revoke this authorization (except to the extent that actions has already been taken) by written or oral communication. I also understand it is my right to inspect the information 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 abilities 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 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.

_____ _____
Patient/Guardian Date

_____ _____
Witness Date