Chantal Cohen Therapy, LLC

Request/Authorization to Release Confidential Records and Information

RE: Client Name: _____

DOB: _____ **Social Security No:** _____

I hereby authorize:

_____

Name:

_____

Address **City** **State** **Zip Code**

Phone: _____ **Fax:** _____

To Release Records To: Chantal Cohen, MA , LMFT DBA Chantal Cohen Therapy, LLC

by HIPAA Compliant Fax No.: (907) 202-5452 **Office Number: (907) 346-0252**

For the Following Purpose(s):

❑ Further mental health evaluation, treatment, or care ❑ Rehab program development or services

❑ Treatment planning ❑ Legal ❑ Other: _____

Type of Communication ❑ Written ❑ Verbal ❑ Other

Information to be Released:

❑ Intake and Discharge Summaries ❑ Mental Health Assessments ❑ Treatment Plans

❑ Progress notes, and treatment or closing summary ❑ Other: _____

This release is in effect from: Start Date: _____ to End Date: _____

I understand this request/authorization to release records and information is voluntary. I understand the nature of this request, the records, their contents, and the likely consequences and implications of their release. I understand that I may revoke this voluntary consent at any time before the end date, not to exceed one year.

_____ _____

Signature of client or guardian Printed name Date

_____ _____

Chantal Cohen, MA, LMFT Date